

TWIN II

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02849

## CERTIFICATE OF DEATH

1st. 10 07 02842

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb <u>23-2</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> d. STREET ADDRESS <u>Route 2 Box 248</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy ARMSTRONG</u> First Middle Last 4. DATE OF DEATH Month Day Year <u>FEBRUARY 20 1967</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>NEGRO</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 20 1967</u> 9. AGE (In years last birthday) yrs. <u>5</u> Months Days Hours Min <u>31</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Armstrong</u> 14. MOTHER'S MAIDEN NAME <u>Evelyn Schoolfield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Evelyn S. Armstrong</u> Address <u>Pocomoke, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 760 gms)</u> DUE TO (b) <u>8800x</u> DUE TO (c) <u>5 min</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/20</u> , 19 <u>67</u> to <u>2/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/20</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred C Kells</u> 22c. PHYSICIAN'S NAME (Type) <u>—</u>		22b. DATE SIGNED <u>2/20/67</u> 22d. ADDRESS <u>—</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-23-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Meth. Cem.</u> 23d. LOCATION (City or Town) (County) (State) <u>Pocomoke Wor. Md.</u>		24. FUNERAL DIRECTOR <u>—</u> ADDRESS <u>New Church, Va.</u> 25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>—</u> DATE <u>FEB 24 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Baltimore Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
02850					CERTIFICATE OF DEATH					02843					
1. PLACE OF DEATH a. COUNTY Wicomico					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.					b. COUNTY Worcester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS Route 2 Box 248					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Baby Girl Armstrong					4. DATE OF DEATH Month February 20					Day 19					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 20, 1967		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. 7 50			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY Infant				11. BIRTHPLACE (County & State, or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Armstrong					14. MOTHER'S MAIDEN NAME Evelyn Schofield										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Evelyn S. Armstrong Pocomoke, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Immaturity (Birth wt 670 gms) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH approx 2 1/2 hrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 2/20, 1967, to 2/20, 1967, that (I) (we) las saw the deceased alive on 2/20, 1967 and that death occurred at 7:30 P.M. from causes and on the date stated above															
22a. SIGNATURE [Signature]					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22b. DATE SIGNED 2/25/67					
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
Burial		2-23-67		Trinity Meth. Cem.		Pocomoke		Wor.		Md.					
24. FUNERAL DIRECTOR [Signature]					ADDRESS New Church, Va.					25a. REC'D BY REGISTRAR DATE FEB 24 1967		25b. REGISTRAR'S SIGNATURE [Signature]			

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury Fruitland 221</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>MOORE AVENUE</u> <u>Peninsula General Hospital</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>AYRES</u>				4. DATE OF DEATH Month Day Year <u>FEBRUARY 27 1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEBRUARY 27 1907</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Ayres</u>				14. MOTHER'S MAIDEN NAME <u>Baulah</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Baulah Ayres Fruitland Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity - 465 gms</u> 776X DUE TO (b) <u>Premature</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>8:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>William C. Morgan</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/4/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Church</u>		23d. LOCATION (City or Town) (County) (State) <u>Taylor Gate Md.</u>	
24. FUNERAL DIRECTOR <u>Clinton H. Stewart</u>				25a. REC'D BY REGISTRAR <u>MAR 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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12250



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02852

CERTIFICATE OF DEATH

02844

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>305 East 4th Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alfred John Bailey</b>		4. DATE OF DEATH Month Day Year <b>February 14 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1913</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna. R.R.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Laurel, Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Bailly</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Nichols</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>221-09-4350</b>	
17. INFORMANT <b>Mrs. Grace D. Bailey</b>		Address <b>305 East 4th Street Laurel, Delaware</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism suspected.</b> <b>466X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Phlebotrombosis rate undetermined</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 Cause of Death - pulm. embolism (2) Rheumatoid arthritis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>01-28</b> , 19 <b>67</b> , to <b>02-14</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>02-14</b> 19 <b>67</b> , and that death occurred at <b>5:45</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Joseph C. F. [Signature]</b>		22b. DATE SIGNED <b>2-14-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Medical Center</b>		22d. ADDRESS <b>Medical Center</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-16-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Junior Order Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Near Preston, Maryland</b>
24. FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalsburg, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 20 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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CERTIFICATE OF DEATH

02845

1. PLACE OF DEATH a. COUNTY <b>Wicomico County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN lb <b>11 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b> d. STREET ADDRESS <b>—</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Wesley BAKER</b>		4. DATE OF DEATH Month Day Year <b>February 24 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 31, 1890</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Wicomico-Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Slidell Baker</b>		14. MOTHER'S MAIDEN NAME <b>Anna Jane Donaway</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-22-7691</b>	
17. INFORMANT <b>Everett Baker</b>		Address <b>Pittsville, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema.</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>BronchoPneumonia</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>7 years</b> <b>10 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>February 13, 1967</b> , to <b>February 24, 1967</b> , that (I) (we) lost the deceased alive on <b>February 24, 1967</b> , and that death occurred at <b>11:50 AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>C. H. Winnacott</b>		22b. DATE SIGNED <b>2/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. C. H. Winnacott</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/26/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grace Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Pittsville, Maryland</b>
24. FUNERAL DIRECTOR <b>Charles Judge</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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STATE OF MICHIGAN

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FEB 2 1981

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02854

## CERTIFICATE OF DEATH

02846

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>		c. LENGTH OF STAY IN 1b <u>33 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>		d. STREET ADDRESS <u>Deer's Head State Hospital</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3 NAME OF DECEASED</b> (Type or print) First Middle Last <u>Luther Thomas Baxter</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>Feb. 26 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27-1887</u>
9. AGE (In years last birthday) Yrs <u>79</u>		IF UNDER 1 YEAR Months Days Hours Min <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Baxter</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Frampton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service) <u>15-12-1002</u>		16. SOCIAL SECURITY NO. <u>15-12-1002</u>	
17. INFORMANT <u>Mrs. John Nash--Chester, Maryland</u>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> DUE TO (b) <u>Broncho - Pn.</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>10-14 days</u> <u>--</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral Thrombosis with right Hemiplegia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 24, 1967</u> , to <u>Feb. 26, 1967</u> , that (I) (we) lost saw the deceased alive on <u>Feb. 26, 1967</u> , and that death occurred at <u>9 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>C. H. Winnacott</u>		22b. DATE SIGNED <u>2-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. H. Winnacott, M.D.</u>		22d. ADDRESS <u>Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 28</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		23d. LOCATION (City or Town) (County) (State) <u>Stevensville, Md.</u>	
24. FUNERAL DIRECTOR <u>Edgar L. Lane Church Hill Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02855

## CERTIFICATE OF DEATH

02847

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>3 Wks.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>306 N. Div. St.,</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>MAUDE JULIA BERRY</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>FEBRUARY 2 19 67</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/6/1893</b>		9. AGE (in years last birthday) <b>73</b> yrs IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Sales Lady</b>		11. BIRTHPLACE (County & State, or foreign country) <b>N.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO <b>212-03-0907</b>		17. INFORMANT Address <b>Mr. E.R. White Jr. Park Ave. Salisbury, Md.</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Renal Failure</b> <b>470X</b> DUE TO (b) <b>Hypertensive Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ Years _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebrovascular Accident</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>January 16, 1967</b> , to <b>February 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>February 1, 1967</b> , and that death occurred at <b>5:39 P.M.</b> , from causes and on the date stated above									
22a. SIGNATURE <b>Thomas P. Bigbee</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <b>Feb. 2, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas P. Bigbee</b>						22d. ADDRESS <b>Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2-5-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Episcopal Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Pocomoke, Maryland</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Hille Funeral Home Salisbury, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





02856

## CERTIFICATE OF DEATH

02848

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Lane, Fruitland</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>						d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>James</b>		First		Middle		Last <b>Bivans</b>		4. DATE OF DEATH <b>FEBRUARY 12 1967</b>		Month		Day		Year	
5 SEX <b>MALE</b>		6 COLOR OR RACE <b>NEGRO</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>2 1895</b>		9. AGE (in years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>		11. BIRTHPLACE (County & State or foreign country) <b>Pocomoke MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>SARAH HUTT</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Phillip Hutt - Cedar Lane Fruitland, Md.</b>									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>443X</b> DUE TO (b) <b>HTASCD</b> DUE TO (c) <b>U.S.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>2/11</b> , 19 <b>66</b> , to <b>2/12</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/12</b> , 19 <b>67</b> , and that death occurred at <b>7:30</b> P.M. from causes and on the date stated above.															
22a. SIGNATURE <b>George H. Hermon</b>						M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-17-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>				23d. LOCATION (City or Town) (County) (State) <b>St. Paul Office Somers, Md.</b>							
24. FUNERAL DIRECTOR <b>Bretta S. Jolley - Jersey Rd St 13 Salisbury, Md.</b>						ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Johnnie Jones</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>CERTIFICATE OF DEATH</b>											
02857		02849									
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>205 Powell Ave.</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Frances Bradley</b>						4. DATE OF DEATH Month Day Year <b>Feb. 7, 1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 10, 1893</b>		9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John T. Green</b>						14. MOTHER'S MAIDEN NAME <b>Sallie Polk</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>						16. SOCIAL SECURITY NO. <b>217-03-7744</b>					
15. INFORMANT <b>Mr. Milton A. Bradley</b>						Address <b>205 Powell Ave. Salisbury, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Hypertensive cerebrovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Not Known</b> (c) <b>Not Known</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Not Known</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <b>1/31/67 to 2/7/67</b> 21. I certify that (I) (this hospital) attended the deceased from <b>1/31/67</b> to <b>2/7/67</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>1/31/67</b> and that death occurred at <b>11:31 AM</b> from the causes and on the date stated above. 22a. SIGNATURE <b>Thomas F. Wallace</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Thomas F. Wallace</b> 22d. ADDRESS <b>Salisbury, Md.</b> 22b. DATE SIGNED <b>FEB 9 1967</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF <b>2-10-1967</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b> 23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas F. Wallace</b> ADDRESS <b>Salisbury, Md.</b> 25a. REC'D BY REGISTRAR <b>FEB 9 1967</b> 25b. REGISTRAR'S SIGNATURE <b>James J. Jones</b>											

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

02858

02850

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>Peninsula General Hospital</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Accomack</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hallwood</b> d. STREET ADDRESS <b>Hallwood</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marine Good</b>		4. DATE OF DEATH Month Day Year <b>Jan 20, 1967</b>		5. SEX <b>M</b>	
6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 20, 1894</b>	
9. AGE (In years last birthday) <b>73</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meltonia - Va</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>M.S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William H. Bull</b>	
14. MOTHER'S MAIDEN NAME <b>Kitty T. Baker</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>225-61-7021</b>	
17. INFORMANT <b>Mrs. Marine Bull</b>		18. ADDRESS <b>Hallwood Va</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>1600</b>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Past operative Surgery on oral Cavity</b> DUE TO (c) <b>because of Coccarina 7 acute aspiration</b>		21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>		22. AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		23c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
23d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		23e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/10/65</b> , 19 <b>65</b> , to <b>9/24/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>9/24</b> , 19 <b>67</b> , and that death occurred at <b>9:40</b> M, from causes and on the date stated above.		22a. SIGNATURE <b>Donald F. Fisher, Jr.</b>		22b. DATE SIGNED <b>2/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Donald F. Fisher, Jr.</b>		22d. ADDRESS <b>Horsely, Va</b>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>2/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley</b>	
23d. LOCATION (City or town) (County) (State) <b>mean Va</b>		23e. REC'D BY REGISTRAR <b>FEB 28 1967</b>		23f. REGISTRAR'S SIGNATURE <b>Richard Johnson</b>	
23g. FUNERAL DIRECTOR <b>Richard Johnson</b>		23h. ADDRESS <b>Parkburg, Va.</b>		23i. REGISTRAR'S SIGNATURE <b>Richard Johnson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02853						02851					
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RFD 3</u>						d. STREET ADDRESS <u>RFD 3</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Isaac Calloway</u>						4. DATE OF DEATH Month Day Year <u>Feb 3 1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 30 1896</u>		9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired trainman</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. R. R.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Isaac Merrill Calloway</u>						14. MOTHER'S MAIDEN NAME <u>Mary Virginia Phillips</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>WW I</u>						16. SOCIAL SECURITY NO. <u>717-07-8296</u>		17. INFORMANT Name Address <u>Martha Calloway Delmar Del</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>					
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral arteriosclerosis, encephalopathy</u>						5 yrs					
DUE TO (c) <u>aspiration pneumonia</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>Feb 3 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 2 1967</u> , and that death occurred at <u>7P</u> M., from the causes and on the date stated above.											
22a. SIGNATURE <u>L.V. Sohler</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>L.V. Sohler</u>						22d. ADDRESS <u>Delmar, Md.</u>					
23a. BURIAL, CREMATION, REMOVE (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>Burial</u>		<u>2/6/67</u>		<u>St Stephens</u>		<u>Delmar</u>		<u>Del</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Marcel Leland Howe</u>						ADDRESS <u>Delmar Del</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be removed and the certificate be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

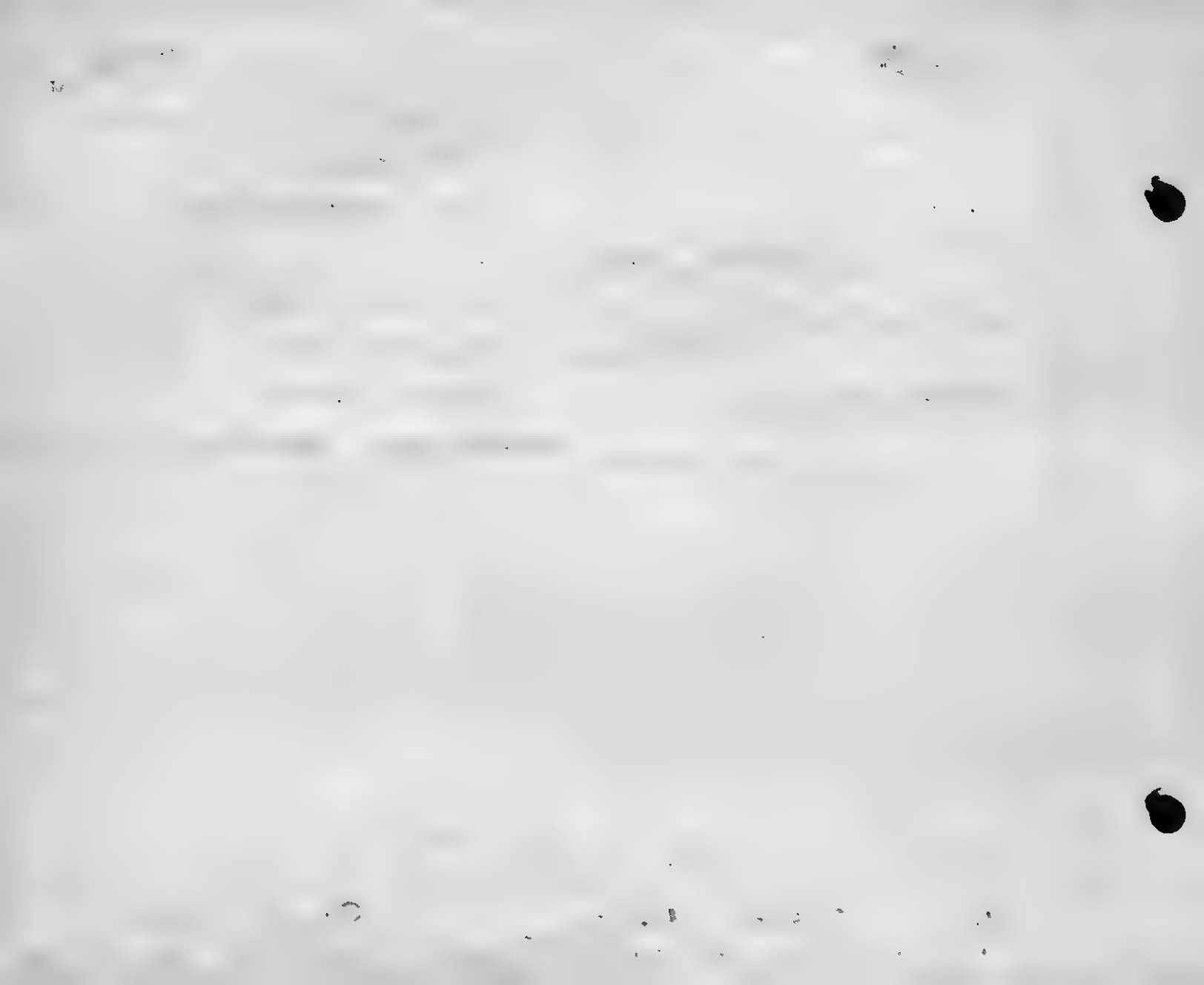
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02860

02852

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>Peninsula General Hospital</u> NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>726 Westover Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Edward Saul Collins</u>		4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1967</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-14-1893</u>		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) <u>73</u> yrs. Months <u>7</u> Days <u>3</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SNOWHILL, Md</u>				11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>William Milbourne</u>				14. MOTHER'S MAIDEN NAME <u>SARAH COLLINS</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>LAURA COLLINS - 726 Westover Dr. Salisbury</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>1/22/1 Cardiac-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>Myocarditis</u> (a), stating the underlying cause last. (c) <u>Acute Atherosclerotic Bronchitis; Emphysema</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</u> <u>Unk.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Atherosclerotic Bronchitis; Emphysema</u>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 17, 1967</u> to <u>Jan. 17, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan. 17, 1967</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>G. Herbert Sembley</u>				22b. DATE SIGNED <u>2/21/67</u>				22c. PHYSICIAN'S NAME (Type) <u>G. Herbert Sembley M.D.</u>				22d. ADDRESS <u>Salisbury, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-23-67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>				23d. LOCATION (City, town or county) (State) <u>Snow Hill, Wico - Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Loretta B. Jolley</u>				24a. ADDRESS <u>Jersey Rd. Rt. #2 Salisbury, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>				25b. REGISTRAR'S SIGNATURE			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02861

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02853

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>23-1</u>	
d. NAME OF HOSPITAL OR INST TUTION (If not in hospital, give street address) <u>DOA Peninsula General Hospital</u>		e. STREET ADDRESS <u>Richardson's Labor Camp</u>	
3 NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>COLLINS</u> Last <u>COLLINS</u>		4 DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>67</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 5, 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>	9. AGE (In years lost birthday) y's <u>61</u>
11 BIRTHPLACE (State or foreign country) <u>P.C.</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN JENNETT</u>		14. MOTHER'S MAIDEN NAME <u>James Collins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>231-10-0610</u>		16. SOCIAL SECURITY NO <u>231-10-0610</u>	
17. INFORMANT <u>James Collins</u>		Address <u>Pittsville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 4 11 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Moyer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>409 Camden Ave., Salisbury, Md.</u>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE TIME OF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>West</u>		25a. REC'D BY REGISTRAR <u>Personnel</u>	
25b. DATE <u>Mar 7 1967</u>		25c. REGISTERED SIGNATURE <u>James Collins</u>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02862

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02854

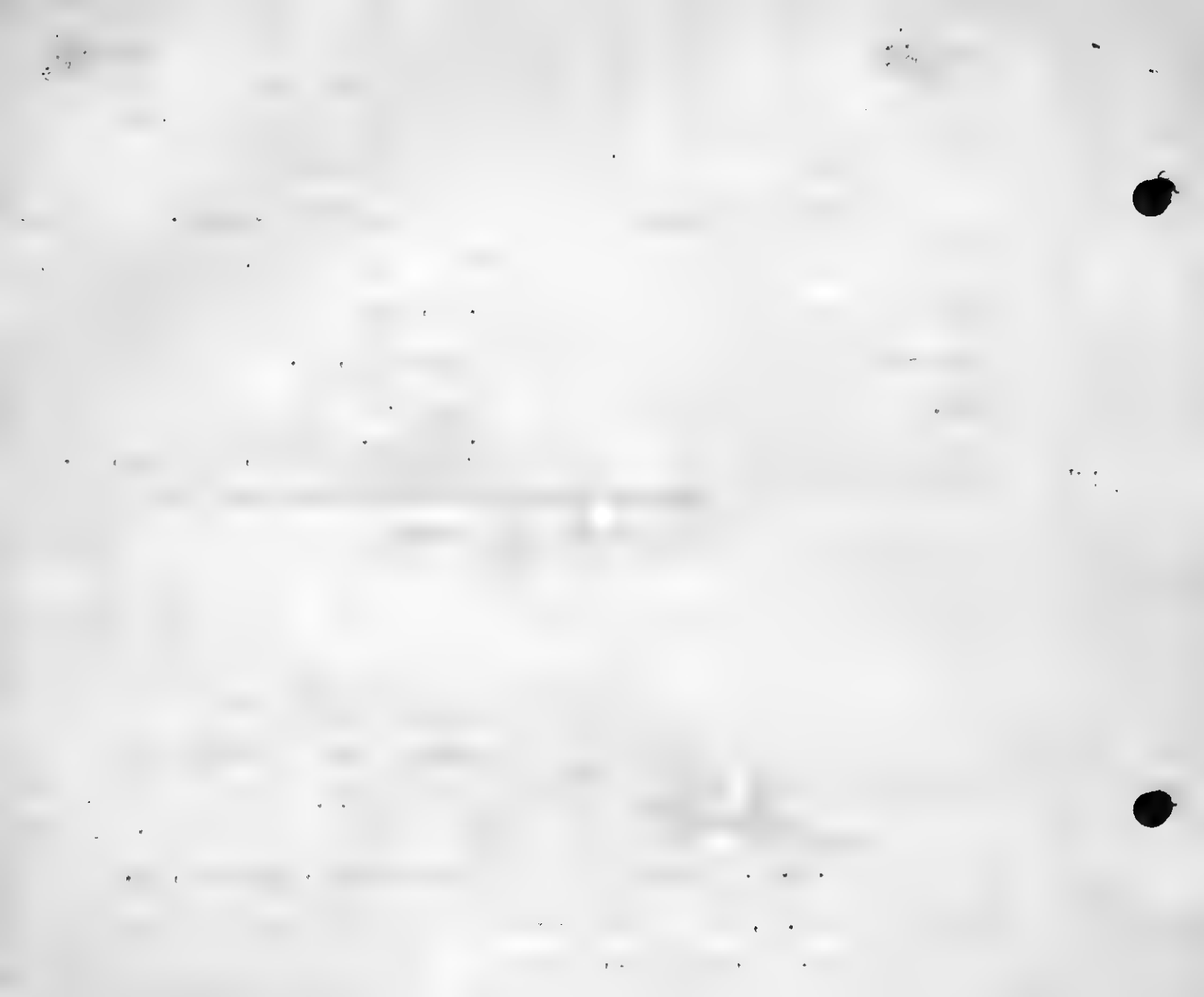
1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>409 Lake St.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE STANLEY COOK</u>		4 DATE OF DEATH Month Day Year <u>2-3-67</u> 19	
5 SEX <u>M</u>	6 COLOR OR RACE <u>AA</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>April 17-1903</u>
9 AGE (In years last birthday) <u>63</u> yrs		10 F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11 BIRTHPLACE (State or foreign country) <u>Wet. piguiv</u>	
12 CT ZEN OF WHAT COUNTRY <u>U.S.A.</u>		13 FATHER'S NAME <u>Joseph J. Cook</u>	
14 MOTHER'S MAIDEN NAME <u>Mary Frances Redell</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>107-143539</u>	
16 SOCIAL SECURITY NO <u>107-143539</u>		17 INFORMANT <u>Robinson Edward Cook</u> Address <u>110 S. Main St - Salisbury</u>	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>470X</u> IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTEING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, D.D.</u> M.D.		22. DATE SIGNED <u>February 6, 1967</u>	
EXAMINER'S NAME (Type) <u>409 Camden Ave., Salisbury, Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Old Fellow</u>	23d. LOCATION (City or Town) (County) (State) <u>Wet. piguiv</u> <u>Nico md</u>
24. FUNERAL DIRECTOR <u>Jolley Funeral Home, Salisbury, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02863					02855						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY <b>Wicomico</b>					a. STATE <b>Maryland</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>					b. COUNTY <b>Wicomico</b>						
c. LENGTH OF STAY IN 1b <b>Adm. in 1 D 2/1/67</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>					d. STREET ADDRESS <b>226 Monticello Ave.</b>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			<b>PAULINE KATHERINE</b>		<b>CULVER</b>				Month <b>February</b> Day <b>2</b> Year <b>1967</b>		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH			9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
<b>Female</b>	<b>White</b>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>Jan. 13, 1904</b>			<b>63 yrs.</b>		Months <b>0</b>	Days <b>19</b>	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pa.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>(Unk.)</b>						14. MOTHER'S MAIDEN NAME <b>Freida Ott</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mr. Wayne A. Culver (Son)</b>			Address <b>226 Monticello Avenue, Salisbury, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized metastatic carcinoma of colon</b> DUE TO (b) <b>Carcinoma of colon</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>N/A</b>								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>May, 1963</b> to <b>2/2/67</b> , that (I) (we) last saw the deceased alive on <b>2/2/1967</b> , and that death occurred <b>at 12:05 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>[Signature]</b>						22b. DATE SIGNED <b>Feb. 3 /1967</b>					
22c. PHYSICIAN'S NAME (Type) <b>Dr. G. J. Burton</b>						22d. ADDRESS <b>Medical Center, Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Feb. 4, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bridgeville Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Bridgeville, Delaware</b>			
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>DATE B 6 1967</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



02864

## CERTIFICATE OF DEATH

02856

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>10 weeks</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>32 Greenway Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>JACKSON</b> Last <b>Custis, JR.</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1921</b> 9. AGE (In years last birthday) <b>45 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Drug</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Somerset County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Jackson Custis, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Stanford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes WW 2</b>		16. SOCIAL SECURITY NO <b>218-10-8059</b>	
17. INFORMANT <b>Mrs Beverly Custis, Pocomoke City, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>466X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (b) <b>Pulmonary emboli, from phlebotrombosis</b> DUE TO (c) <b>Rt. leg; Bilateral lower lobe pneumonia;</b> INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post-operative peritonitis; Rt. subhepatic abscess; duodenal fistula; gastric ulcer; cholecystomy</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>12/3</b> , 1966, to <b>2/10</b> , 1967, that (1) (we) last saw the deceased alive on <b>2/10</b> , 1967, and that death occurred at <b>6:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>William P. Sadler</b> M.D.		22b. DATE SIGNED <b>2/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>William P. Sadler</b>		22d. ADDRESS <b>Medical Center Salisbury, Wic, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-13-1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>First Baptist</b>	23d. LOCATION (City or Town) (County) (State) <b>Pocomoke City Wor. Md.</b>
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 17 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #8 & 9 Filed 2/20/67

02865

CERTIFICATE OF DEATH

02857

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>967 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julius</b> Middle <b>DARBY</b> Last <b>DARBY</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>14</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/20/89</b> 9. AGE (In years last birthday) <b>Unknown</b> Lys.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food Factory</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>266-18-069A</b>	
17. INFORMANT <b>E.K. Williams</b>		Address <b>4 Church ST Bridgeville, Del.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardio vascular disease</b> DUE TO 6382 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Lues, latent treated.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 22</b> , 1964, to <b>February 14</b> , 1967, that (I) (we) last saw the deceased alive on <b>February 14</b> , 1967, and that death occurred at <b>8:40 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>C. H. Winnacott</b>		22b. DATE SIGNED <b>2-14-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. C. H. Winnacott</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-18-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Middleford Sussex Del</b>
24. FUNERAL DIRECTOR <b>Wm. A. Berry Jr - Milford, Del</b> <b>H.E. Nordesty &amp; Sons - Bridgeville, Del.</b>		25a. RECEIVED BY REGISTRAR DATE <b>FEB 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

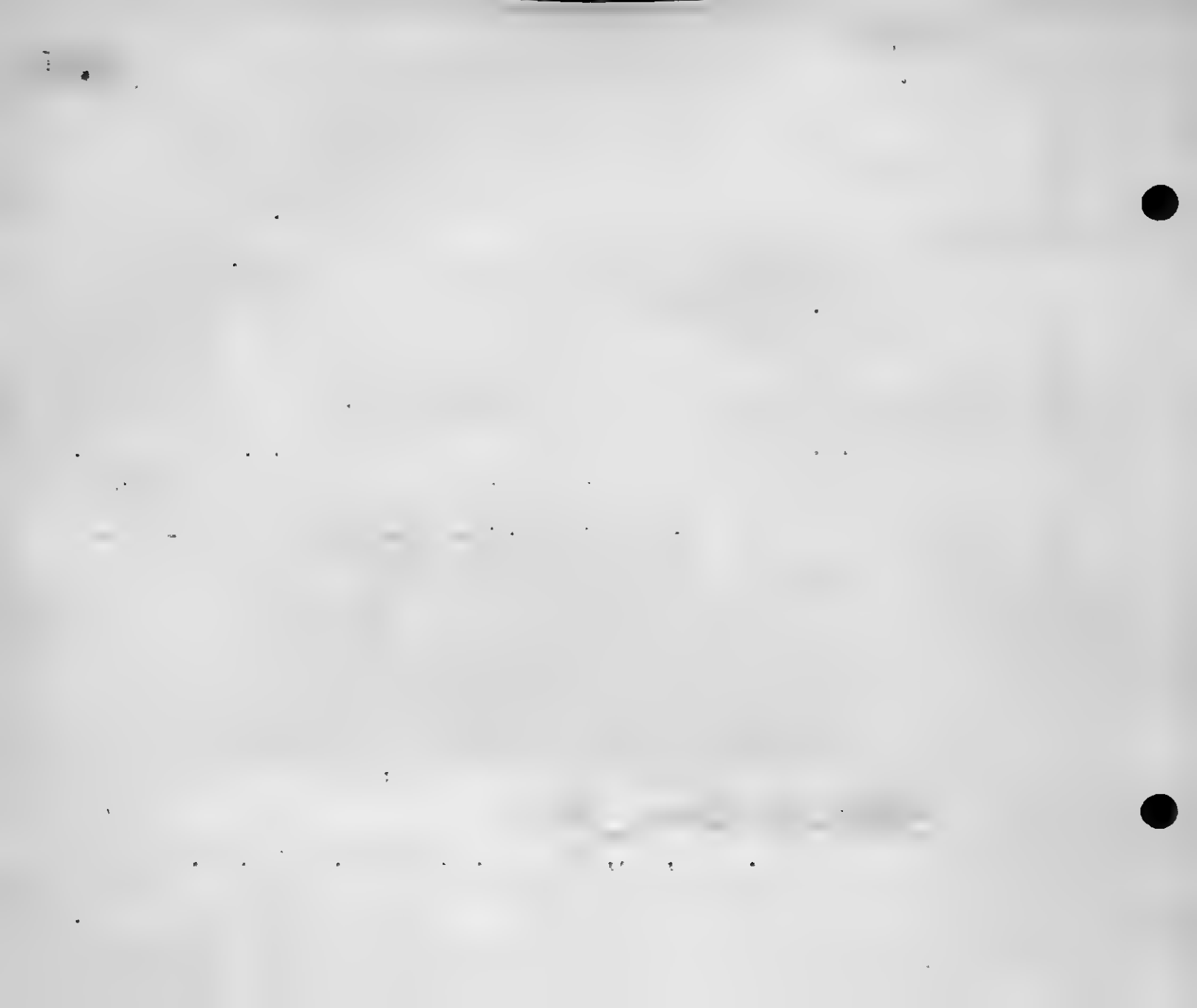


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

<div style="display: flex; justify-content: space-between;"> <span>02866</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>02858</span> </div> <div style="text-align: center;"> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pinensula General Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>683 Fitzwater St.</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Clayton Dashiield (Dashiields)</u> First Middle Last <b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>C.</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>April 4, 1890</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>76</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.						<b>4. DATE OF DEATH</b> <u>Feb. 10, 1967</u> Month Day Year <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Butler</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b>					
<b>13. FATHER'S NAME</b> <u>Unknown</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Dashiield</u>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>U.S.A.</u> <b>16. SOCIAL SECURITY NO.</b> <u>4201</u> <b>17. INFORMANT</b> <u>Fulton Dashiield R.F.D. 1 Hebron Md.</u> Address					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardiovascular Disease</u> (a), stating the underlying cause last. DUE TO (c) 3 1/2 Years INTERVAL BETWEEN ONSET AND DEATH											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. g.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20a. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that (I) (M.D.)</b> <u>Clayton Dashiield</u> attended the deceased from <u>4/6/63</u> 19 <u>PM</u> to <u>2/1/67</u> , 19 <u>PM</u> , that (I) <u>did</u> last saw the deceased alive on <u>2/1/67</u> , 19 <u>PM</u> , and that death occurred at <u>2:15M</u> , from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>Ivory U. Sully, Jr., M.D.</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Ivory U. Sully, Jr., MD</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>P. O. Box 126, Berlin, Md. 21811</u> <b>22b. DATE SIGNED</b> <u>2/14/67</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>2/16/1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Green Acres</u>		<b>23d. LOCATION</b> (City, town or county) <u>Salisbury</u> (State) <u>Md.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Clinton F. Stewart</u> ADDRESS <u>Salisbury, Md.</u>	
<b>25a. REC'D BY REGISTRAR</b> <u>FEB 23 1967</u>						<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles J. ...</u>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02867						02859					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <b>So Wicomico</b>						a. STATE <b>Md.</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jesterville</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jesterville</b>					
c. LENGTH OF STAY IN 1b <b>Life</b>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS <b>Jesterville</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
			<b>JOHN W. DASHIELLS</b>			<b>2/4/67</b>			<b>1967</b>		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<b>M</b>	<b>Negro</b>	<b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>Apr. 10, 1880</b>	<b>86</b> yrs.	<b>177X</b>	<b>Jesterville Md.</b>	<b>U.S.</b>				
13. FATHER'S NAME <b>Dore Bailly</b>						14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>						16. SOCIAL SECURITY NO. <b>410-20-7865</b>					
17. INFORMANT <b>Nathaniel Dashtellis</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma Prostate</b> 177X DUE TO (b) <b>Generalized Adenocarcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Arteriosclerosis - several years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis - several years</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1966</b> to <b>Feb. 4, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan. 24, 1967</b> , and that death occurred at <b>3:59 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>G. Herbert Sembley</b>						22b. DATE SIGNED <b>2/6/67</b>					
22c. PHYSICIAN'S NAME (Type) <b>G. Herbert Sembley</b>						22d. ADDRESS <b>Salisbury Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2/8/67</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Elzeys Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Jesterville Md.</b>		
24. FUNERAL DIRECTOR <b>Anthony E. Ward Crisfield Md.</b>						25a. REC'D BY REGISTRAR <b>Charles Judge</b>					
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						DATE <b>FEB 8 1967</b>					



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02868

## CERTIFICATE OF DEATH

02860

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. CITY OR COUNTY <b>Wicomico</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 16 <b>6 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>Rt. #1</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>DONALD FRANCIS DUNNOCK</b>		4 DATE OF DEATH Month Day Year <b>2 27 1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 15, 1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>	9. AGE (In years last birthday) yrs <b>73</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland, Dorchester</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Matthias M. Dunnock</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>215-38-1081</b>	
17. INFORMANT <b>Mrs. Helen S. Dunnock, Sec 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-21</u> , 19 <u>67</u> to <u>2-24</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>2-27</u> 19 <u>67</u> , and that death occurred at <u>3:10 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Wilber R. Ellis, Jr.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wilber R. Ellis, Jr., M.D.</b>		22d. ADDRESS <b>Medical Center, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-1-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Maryland</b>
24. FUNERAL DIRECTOR <b>Hill Funeral Home Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <u>Wm. F. Baker</u>		25c. REGISTRAR'S SIGNATURE <u>Wm. F. Baker</u>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

<div> <div>Items 1-19-21 Film 336</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div>											
<div>02869</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02861</div>											
<div>1. PLACE OF DEATH</div> <div>a. COUNTY <b>Wicomico</b> MARYLAND</div>						<div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b></div>					
<div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div><b>Salisbury</b></div>				<div>c. LENGTH OF STAY IN</div> <div><b>Salisbury</b></div>		<div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div><b>Salisbury</b></div>				<div>d. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>	
<div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div><b>804 E. Church Street</b></div>						<div>d. STREET ADDRESS</div> <div><b>804 E. Church Street</b></div>					
<div>3. NAME OF DECEASED (Type or print)</div> <div><b>JOHN WILLIAM ELLIOTT, SR.</b></div>			<div>4. DATE OF DEATH</div> <div><b>February 18 1967</b></div>								
<div>5. SEX</div> <div><b>Male</b></div>		<div>6. COLOR OR RACE</div> <div><b>White</b></div>		<div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8. DATE OF BIRTH</div> <div><b>May 25, 1905</b></div>		<div>9. AGE (In years, last birthday)</div> <div><b>61</b> yrs</div>		<div>10. UNDER 1 YEAR</div> <div>Months <b>8</b> Days <b>23</b></div>	
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div><b>Laborer</b></div>				<div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div><b>Window Cleaning Serv. Salisbury, Maryland</b></div>				<div>11. BIRTHPLACE (State or foreign country)</div> <div><b>USA</b></div>		<div>12. CITIZEN OF WHAT COUNTRY?</div> <div><b>USA</b></div>	
<div>13. FATHER'S NAME</div> <div><b>A. Lee Elliott</b></div>						<div>14. MOTHER'S MAIDEN NAME</div> <div><b>Mary Wright</b></div>					
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</div> <div><b>No</b></div>				<div>16. SOCIAL SECURITY NO</div> <div><b>159-03-2050</b></div>		<div>17. INFORMANT Address</div> <div><b>Mrs. Rada C. Elliott (Wife)</b> <b>804 E. Church Street, Salisbury, Maryland</b></div>					
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</div> <div>PART I DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) <b>Epilepsy</b></div> <div>505.0</div> <div>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>(b) _____</div> <div>(c) _____</div>										<div>INTERVAL BETWEEN ONSET AND DEATH</div> <div><b>years</b></div>	
<div>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div>											
<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>											
<div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/></div> <div>CAUSE OF DEATH</div>						<div>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)</div>					
<div>20c. TIME OF INJURY Month, Day, Year</div> <div>Hour a.m. _____ p.m. <b>19</b></div>				<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div>		<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>		<div>20f. (City or town) (County) (State)</div>			
<div>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></div>											
<div>ACTUAL SIGNATURE</div> <div><i>Earl L. Royer</i></div> <div>EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b></div> <div><b>409 Camden Avenue, Salisbury, Md.</b></div>						<div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>Address (Street, city, town, or county)</div>					
<div>22. DATE SIGNED</div> <div><b>February 20/1967</b></div>											
<div>23a. BURIAL, CREMATATION, REMOVAL (Specify)</div> <div><b>Burial</b></div>				<div>23b. DATE THEREOF</div> <div><b>Feb. 21, 1967</b></div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div><b>Mt. Pleasant Cemetery</b></div>		<div>23d. LOCATION (City or Town) (County) (State)</div> <div><b>Wicomico County, Maryland</b></div>			
<div>24. FUNERAL DIRECTOR ADDRESS</div> <div><b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b></div>						<div>25a. REC'D BY REGISTRAR</div> <div><b>FEB 21 1967</b></div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div><i>Charles Judge</i></div>			



02870

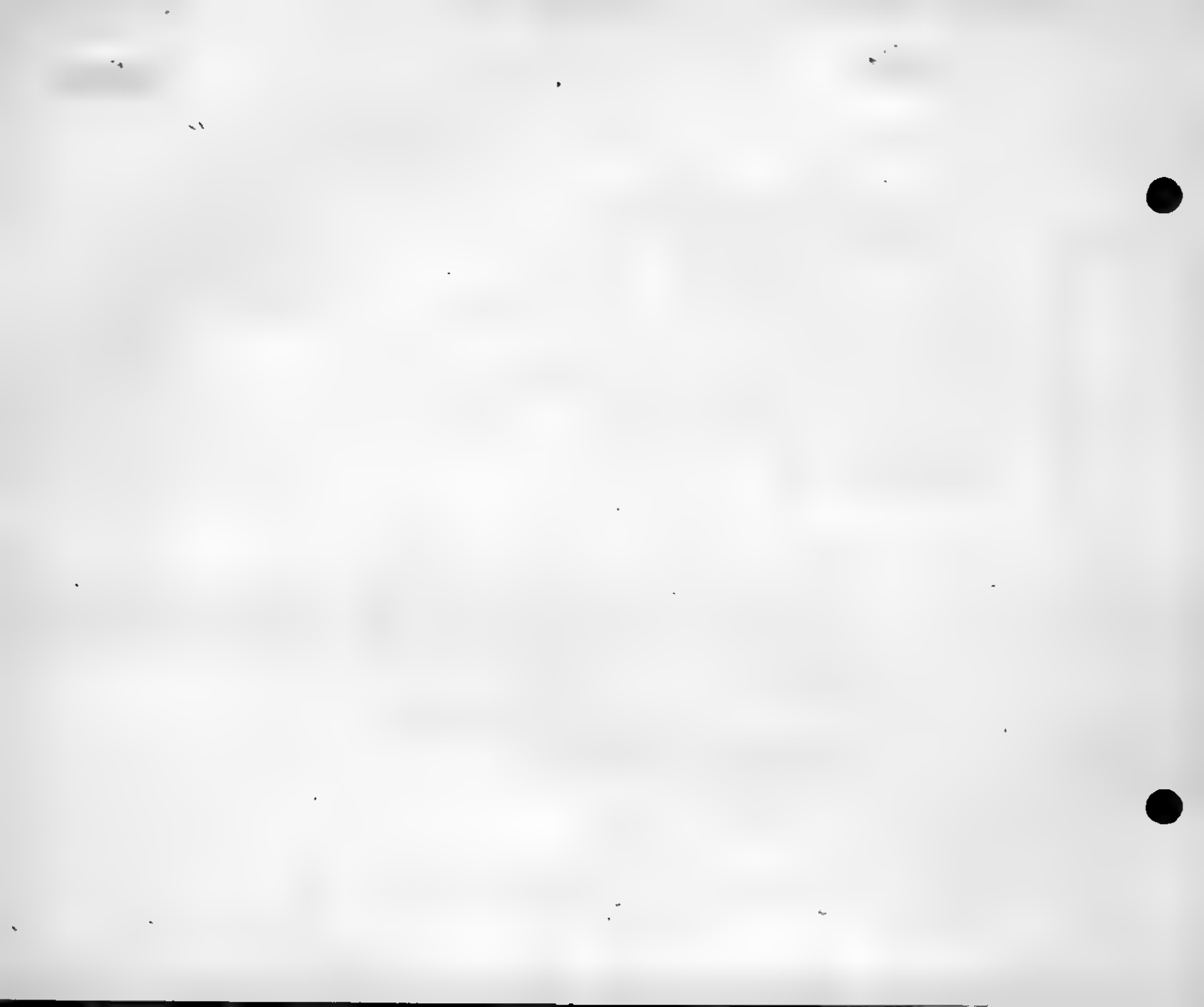
## CERTIFICATE OF DEATH

02862

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>Peninsula General Hospital</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebron, Md.</u> d. STREET ADDRESS <u>Peninsula General Hospital</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LAVRA</u> First Middle Last 5 SEX <u>FEMALE</u> 6 COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>Sept. 5, 1910</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9 AGE (In years) <u>56</u> (lost birthday) <u>55</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>factory</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u> 11 BIRTHPLACE (County & State, or foreign country) <u>Md.</u> 12 CIT. ZEN. OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH Month Day Year <u>February 25 1967</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
13. FATHER'S NAME <u>Edward Evans</u> 14. MOTHER'S MAIDEN NAME <u>Lucretia</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>Lucretia Evans. Accomac, Va.</u> 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>Unknown</u> <u>1 month</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Typhlophritis 1 month of non</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 22, 1967</u> to <u>Jan. 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 23, 1967</u> , and that death occurred at <u>10:45 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>G. Herbert Sembly</u> M.D.		22b. DATE SIGNED <u>2/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly</u>		22d. ADDRESS <u>489 E. Church St. Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-5-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Accomac</u>		23d. LOCATION (City or town) (County) (State) <u>Accomac, Accomac, Va.</u>	
24. FUNERAL DIRECTOR <u>Samuel Savage - New Church, Va.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 2 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

02871

02863

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>19.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MANOKIN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>19.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Lydia C. Fontaine</b>		4 DATE OF DEATH Month Day Year <b>February 16 1967</b>	
5 SEX <b>Female</b>	6. CO. OR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	8 DATE OF BIRTH <b>JAN. 16, 1875</b>
9 AGE (in years last birthday) <b>92</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>ALBANY, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>JOHN CHAMBERLIN</b>		14 MOTHER'S MAIDEN NAME <b>CHRISTINA ROCKEFELLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>320-52-8939</b>	
17. INFORMANT <b>MISS VIRGINIA FONTAINE</b>		Address <b>MANOKIN, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-10</b> , 19 <b>67</b> , to <b>2-16</b> , 19 <b>67</b> (that (I), (we) lost saw the deceased alive on <b>2-16</b> , 19 <b>67</b> , and that death occurred at <b>7P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>W. B. [Signature]</b>		22b. DATE SIGNED <b>2-17-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/19/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MANOKIN PRES. CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>PRINCESS ANNE, MD.</b>	
24 FUNERAL DIRECTOR <b>LEVIN R. WILSON</b>		25a. REC'D BY REGISTRAR <b>PRINCESS ANNE, MD.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 21 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02861

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Delmar</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Peninsula General Hospital</b>		d. STREET ADDRESS <b>R.D. 2</b>	
3 NAME OF DECEASED (Type or print) <b>NANCY S. FRANKLIN</b>		4 DATE OF DEATH Month <b>2-10-67</b> Day <b>19</b> Year <b>19</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10-11-34</b>
9 AGE (In years last birthday) <b>32</b> yrs		IF UNDER 1 YEAR Months <b>32</b> Days <b>32</b> Hours <b>32</b> Min <b>32</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jesse Shortt</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Dickel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Jesse Shortt, Snow Hill, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> DUE TO <b>1750</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Ovarian carcinoma</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>months</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		22. DATE SIGNED <b>February 13, 1967</b>	
EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 13, 1967</b>	23c. NAME OF CEMETERY OR CREMATOR <b>Spence Baptist</b>	23d. LOCATION (City or town) (County) (State) <b>Snow Hill, Maryland</b>
24. FUNERAL DIRECTOR <b>Dennis Funeral Home, Snow Hill, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 15 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John L. Royer</b>			





02873

## CERTIFICATE OF DEATH

02865

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharptown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>						d. STREET ADDRESS <b>R.F.D.L Mardola Md.</b>					
3. NAME OF DECEASED (Type or print) <b>WILBERT Mc KINLEY GAINES</b>						4. DATE OF DEATH <b>FEBRUARY 15 1967</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 20, 1902</b>		9. AGE (In years last birthday) <b>64 yrs</b>		10. F UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Harrison Gains</b>						14. MOTHER'S MAIDEN NAME <b>Martie Truitt</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>213-22-8469</b>		17. INFORMANT <b>Martona Gaines R.F.D.L Mardola Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>YACU</b> (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sanguine right lower leg</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1/25</b> , 19 <b>67</b> , to <b>2/15</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/15</b> , 19 <b>67</b> , and that death occurred at <b>10:20</b> M, from causes and on the date stated above.											
22a. SIGNATURE <b>David J. Gilmore</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2/18/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Methodist</b>		23d. LOCATION (City or Town) (County) (State) <b>Sharptown Md.</b>			
24. FUNERAL DIRECTOR <b>Walter A. Stewart Salis + Co.</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02874

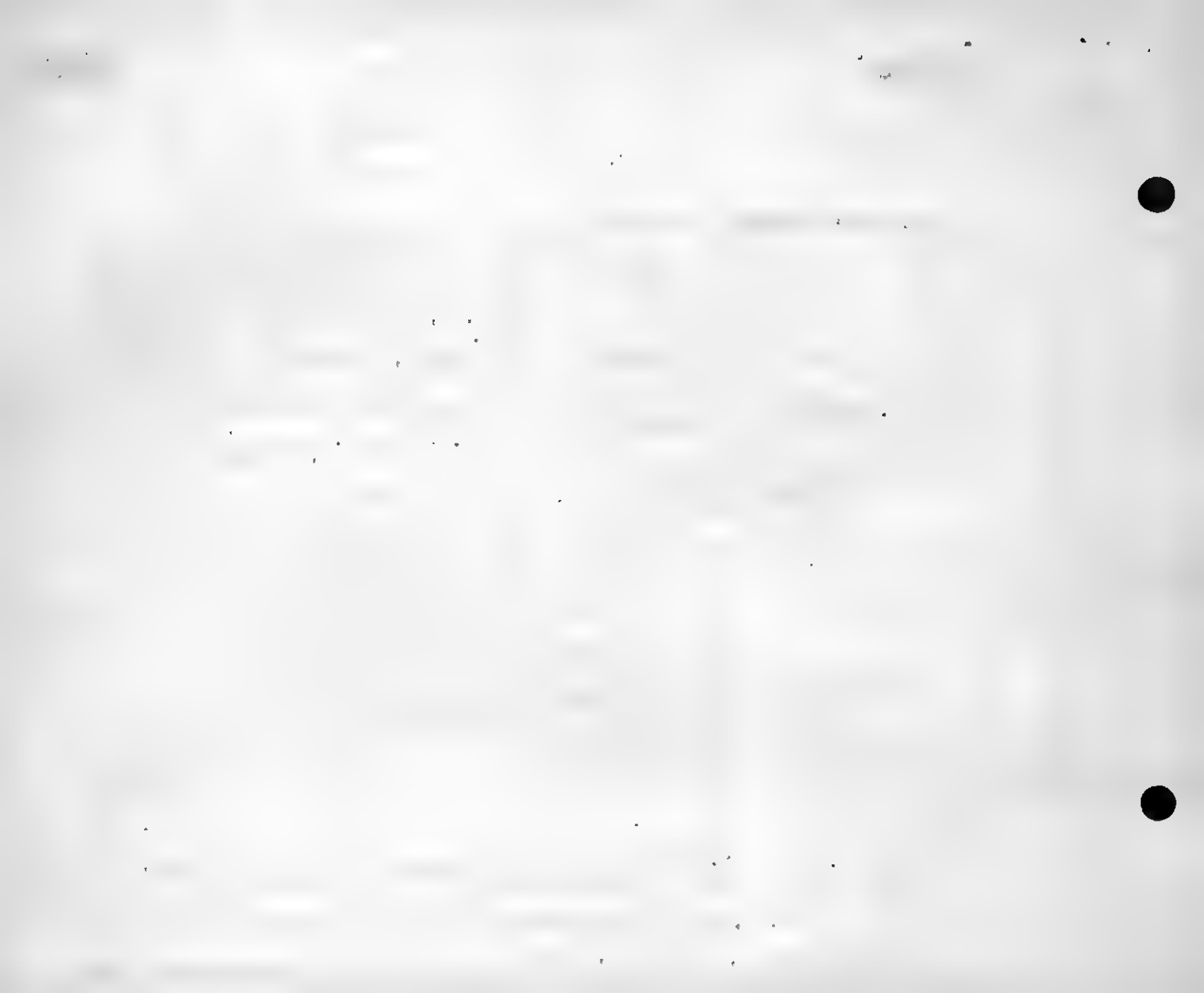
CERTIFICATE OF DEATH

02866

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY (In 15 days) <b>Adm. in 15 17/167</b>		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela</b>	
3 NAME OF DECEASED (Type or print) <b>ROBERT ALLEN GAMBRILL</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		4 DATE OF DEATH Month <b>FEBRUARY</b> Day <b>3</b> Year <b>1967</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>	6 CO. OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 1, 1896</b>
9. AGE (In years last birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>2</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(Retired) Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Hebron, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>James E. Gambrill</b>		14 MOTHER'S MAIDEN NAME <b>Martha Ellen Dashiels</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes War I</b>		16 SOCIAL SECURITY NO <b>N/A</b>	
17. INFORMANT <b>Mrs. Minnie E. Gambrill (Wife)</b> <b>Mardela Springs, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Lymphatic Leukemia</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Chronic obstructive airway disease</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic obstructive airway disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter notation of injury in Part I or Part II at item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 25, 1966</b> to <b>Feb. 2, 1967</b> that (I) (we) last saw the deceased alive on <b>February 2, 1967</b> , and that death occurred at <b>10:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Thomas P. Bigbee</b>		22b. DATE SIGNED <b>Feb. 3 / 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas P. Bigbee</b>		22d. ADDRESS <b>Maryland Avenue, Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 6, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mardela Memorial Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Mardela, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>FEB 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



02875

## CERTIFICATE OF DEATH

02867

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela Springs - Rural</b> d. STREET ADDRESS <b>San Domingo</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lettie Geneva GLAZE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1912</b>
9. AGE (In years last birthday) <b>54 yrs</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer - Marvil Package Company</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sharptown, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James W. Stanley</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Cook</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>222-12-1421</b>	
17. INFORMANT <b>Dora M. Winfield, Wilmington, Del.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HTASCVD</b> DUE TO (c) <b>Cereb.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/23</b> , 1967, to <b>2/7</b> , 1967, that (I) (we) last saw the deceased alive on <b>2/7</b> , 1967, and that death occurred at <b>4 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>George H. Hennen</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 11, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Zion Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Sharptown, Maryland</b>	
24. FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



02876

## CERTIFICATE OF DEATH

02868

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>LIFETIME</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEAL ISLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>MAIN ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WINNIE HARRIS</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 17-1880</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARETAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HUNTING LODGE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZENSHIP OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JABEZ HARRIS</b>		14. MOTHER'S MAIDEN NAME <b>LOVENIA DAYTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>UNKNOWN</b>	
17. INFORMANT <b>MRS VIRGINIA OWENS - PRINCE ANNE MD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>Not known</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/25/1967</b> to <b>2/25/1967</b> that (I) (we) last saw the deceased alive on <b>2/24/1967</b> and that death occurred at <b>4 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>2/25/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		22d. ADDRESS <b>[Signature]</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2-25-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>DEAL ISLAND Som MD</b>
24. FUNERAL DIRECTOR <b>Le Roy Webster - Prince Anne</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 2 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE HEALTH DEPT.

02877

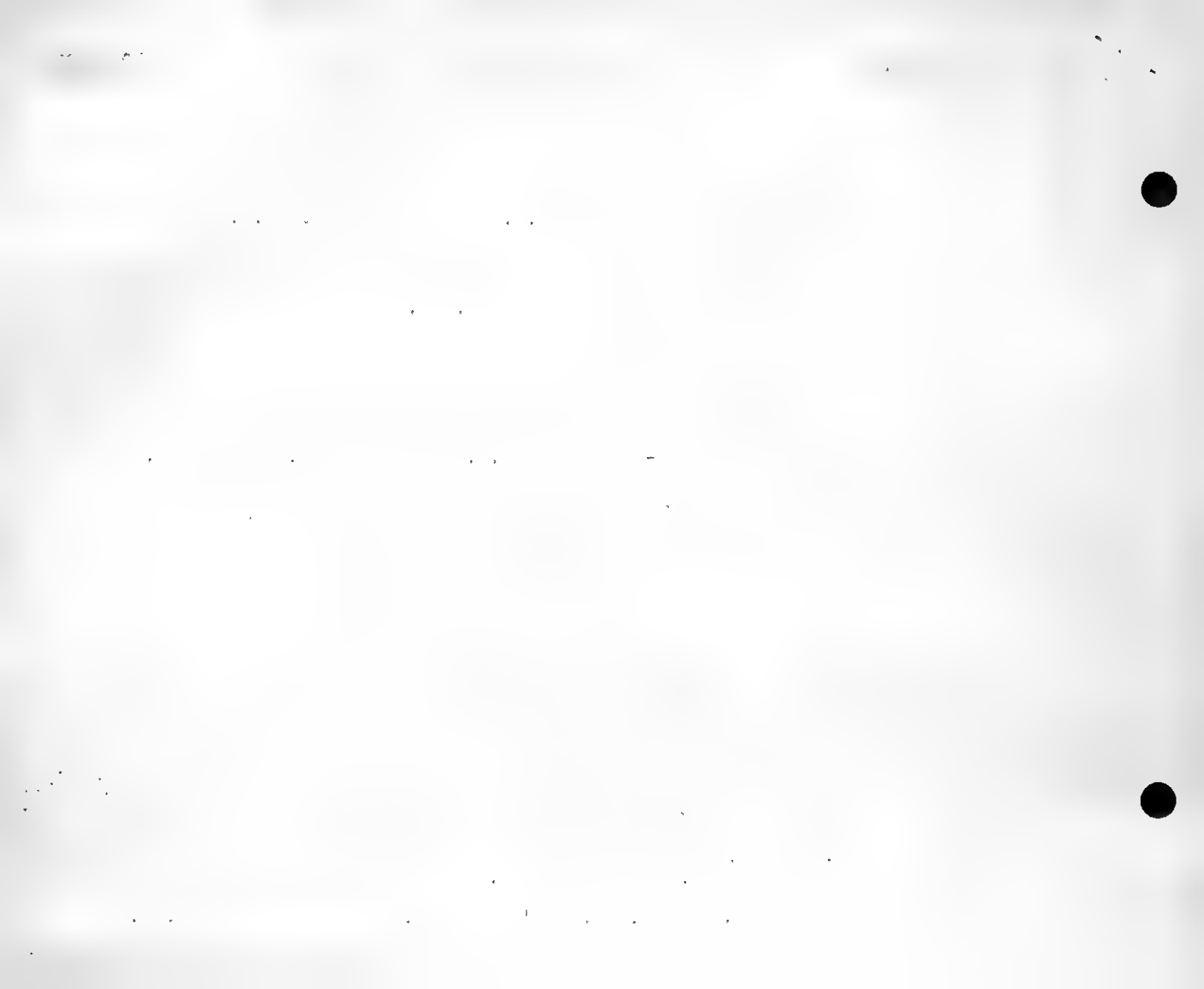
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02869

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital D.O.A.</b>				d. STREET ADDRESS <b>Parker Ave., R.D.#3</b>			
3 NAME OF DECEASED (Type or print) First <b>JOHANNA</b> Middle <b>(NMI)</b> Last <b>HELLINGER</b>				4 DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1967</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Nov. 20, 1897</b>	9 AGE (In years last birthday) <b>69</b> yrs	IF UNDER 1 YEAR Months <b>3</b> Days <b>4</b>	IF UNDER 24 HRS Hours <b>4</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired -Chiropractor</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Karl Heinrich Koch</b>				14. MOTHER'S MAIDEN NAME <b>Emma Kessler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>108-03-4643</b>		17. INFORMANT <b>Louis Hellinger (Husband)</b> <b>R.D.#3, Parker Ave., Salisbury, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Butterfly Scarlet C. J. Hume</b> DUE TO (c) <b>James</b>							INTERVAL BETWEEN ONSET AND DEATH <b>None</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b> M.D. EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
22. DATE SIGNED <b>February 25 / 1967</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Feb. 27, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>J. Wm. Lee's Sons Co.</b>		23d. LOCATION (City or town) (County) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>FEB 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



02878

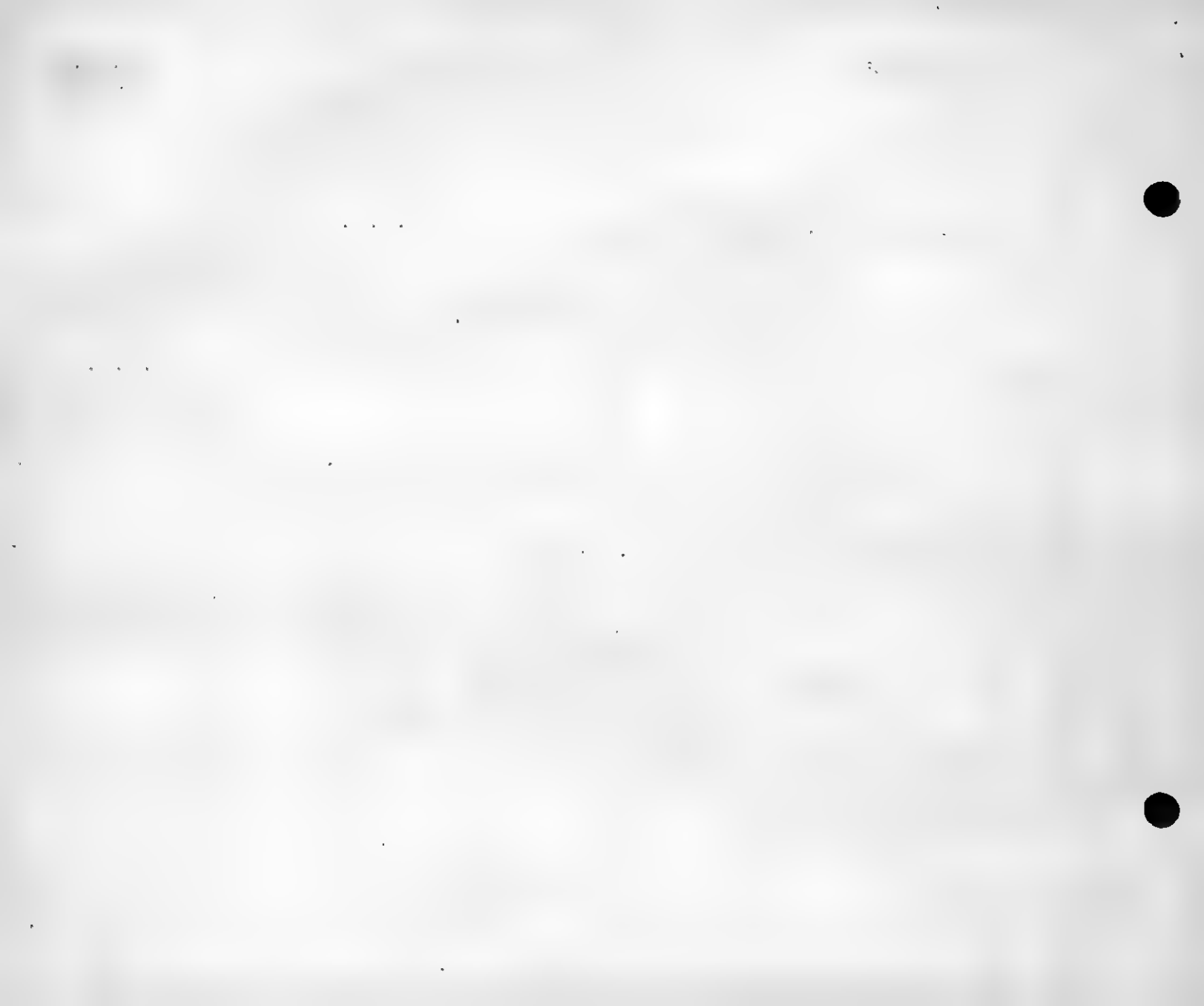
## CERTIFICATE OF DEATH

02870

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Pocomoke City</b> d. STREET ADDRESS <b>R.F.D. 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Willis Reynolds Howard</b>		4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 11, 1898</b>
9. AGE (In years last birthday) <b>68</b>		10. FUNDING 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Produce</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Somerset County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Thomas Howard</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>261-28-7654</b>	
17. INFORMANT <b>Mrs Bertha C. Howard, Pocomoke, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm, ruptured</b> DUE TO (b) <b>Brain trauma</b> DUE TO (c) <b>Head injury</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Alcohol consumption</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>21 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1966</b> to <b>2-18-1967</b> , that (I) (we) last saw the deceased alive on <b>2-18-1967</b> , and that death occurred at <b>7:15 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Robert H. Watson</b> M.D.		22b. DATE SIGNED <b>2-18-1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert H. Watson</b>		22d. ADDRESS <b>Pocomoke City, Md.</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-21-1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>First Baptist</b>	23d. LOCATION (City or Town) (County) (State) <b>Pocomoke City, Wor. Md.</b>
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 23 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02879

## CERTIFICATE OF DEATH

02871

1. PLACE OF DEATH a. COUNTY <b>Wicomico County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b> ✓	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>10 Locust Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Eileen</b> Last <b>HOWELL</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1928</b>
9. AGE (In years last birthday) yrs. <b>38</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>6</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Queen Anne Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John F. Baynard</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Coleman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>219-14-3456</b>	
17. INFORMANT <b>E. J. Baynard, Easton, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meningioma (Left) Frontal Lobe with surgery.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 14, 1962</b> , to <b>February 4, 1967</b> , that (I) (we) last saw the deceased alive on <b>February 4, 1967</b> , and that death occurred at <b>3:33 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W. Thalberg</b>		22b. DATE SIGNED <b>2-6-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L. V. Maldve</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/7/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Easton, Md.</b>	
24. FUNERAL DIRECTOR <b>MORRIS E. NEUNAM &amp; SON, Easton, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>W. Thalberg</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02880

## CERTIFICATE OF DEATH

02872

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN lb <b>1 day</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. STREET ADDRESS <b>N. Division St.</b> f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frances Hudson</b>		4. DATE OF DEATH Month Day Year <b>February 8 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/14/1891</b> 9. AGE (In years last birthday) <b>75 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Saleslady</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Leonard F. Townsend</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Carter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>229-18-2868</b>	17. INFORMANT <b>Fred Hudson Dobbs Ferry, N.Y. 10522</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Coronary Insufficiency</b> DUE TO (c) <b>Heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 1966</b> , to <b>Feb 8, 1967</b> , that (I) (we) last saw the deceased alive on <b>2/8</b> 1967, and that death occurred at <b>7:55 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>George B. Hudson</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REINTERMENT <b>Reinterment</b>	23b. DATE THEREOF <b>2/11/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Maryland</b>
24. FUNERAL DIRECTOR <b>Charles C. Kiet - Salisbury, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 14 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles C. Kiet</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02881

CERTIFICATE OF DEATH

02873

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishopville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>St Martin Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>NOAH J. HUDSON</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/22/1989</u>		9. AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief of Police (Retired) Town Police</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police</u>		11. BIRTHPLACE (County & State or foreign country) <u>W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Hudson</u>				14. MOTHER'S MAIDEN NAME <u>Anna Burch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates at service)		16. SOCIAL SECURITY NO <u>221-20 8742A</u>		17. INFORMANT <u>Elba Hudson - Bishopville - Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4:00 Arteriosclerotic Heart Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 14, 1967</u> , to <u>Feb 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 20, 1967</u> , and that death occurred at <u>5:10 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>David J. Silmore</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Georgetown - Del.</u>	
24. FUNERAL DIRECTOR <u>Ronald James Millstone, Del.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jago</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02882  
02874  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN <u>1B</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>305 N. Clairmont Drive</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanjemoy</u> d. STREET ADDRESS <u>R.D.#1 90A</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ARLIE CARTER HUGHES</u> First Middle Last 4. DATE OF DEATH <u>February 15 1967</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 20, 1908</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>58</u> yrs. 10. IF UNDER 1 YEAR <u>1</u> Mo. <u>25</u> Days 11. IF UNDER 24 HRS. <u>25</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Truck Driver</u> 13. FATHER'S NAME <u>James Harvey Hughes</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Const. Co.</u> 14. MOTHER'S MAIDEN NAME <u>Phoebie Powers</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Mahan, West Virginia</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>400-07-7403</u> 17. INFORMANT <u>Mrs. Nellie Hughes (Wife)</u> (If yes, give name or dates of service) <u>R.D.#1 90A, Nanjemoy, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1621</u> DUE TO <u>Bronchogenic carcinoma</u> Conditions, if any, which gave rise to immediate cause (b) } DUE TO <u>10 months</u> (a), stating the underlying cause last. (c) }		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) <u>Dermatomyositis</u>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>		20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>While</u> <input type="checkbox"/> <u>Not While</u> <input type="checkbox"/> Hour a.m. <u>19</u> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Fruitland, Maryland</u> p.m. <u>19</u> 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-3</u> <u>1967</u> to <u>3-15</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>2-5</u> <u>1967</u> and that death occurred at <u>7A</u> <u>2-15-67</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Hubert R. White, Jr.</u> M.D. 22b. DATE SIGNED <u>Feb. 16/1967</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Hubert R. White</u> 22d. ADDRESS <u>Fruitland, Maryland</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Feb. 18, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Lewis Family Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Willards, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</u> ADDRESS <u>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</u>		25. REGISTRAR'S SIGNATURE <u>John J. Jones</u> DATE <u>Feb 20 1967</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

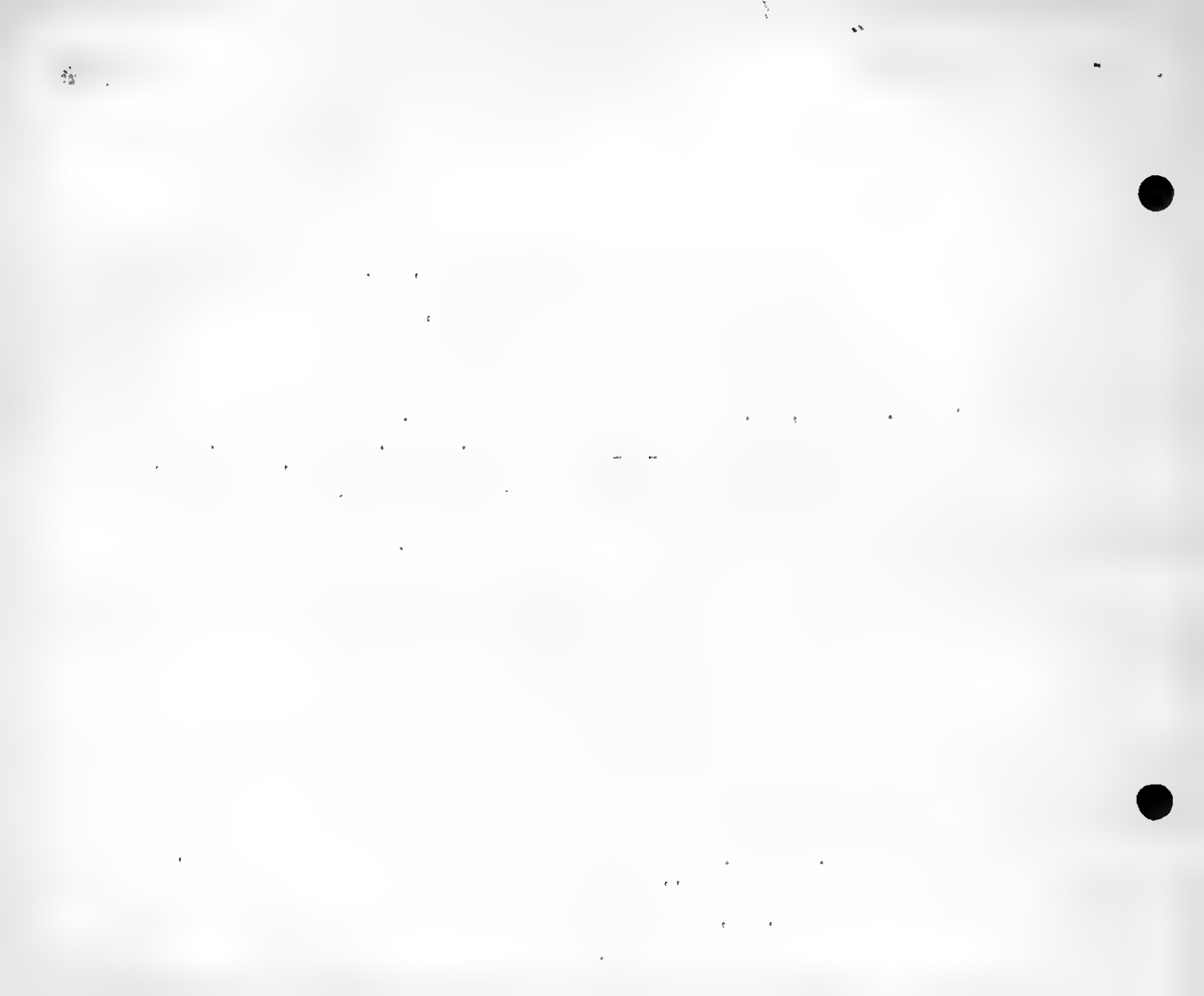
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02875

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>311 Locust Terrace</b>			d. STREET ADDRESS <b>311 Locust Terrace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>JABE</b> Middle <b>DEXTER</b> Last <b>HYLTON, JR.</b>			4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 67</b>		
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 23, 1920</b>		9 AGE (in years last birthday) <b>46 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plant Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>South Dakota</b>	
13. FATHER'S NAME <b>Jabe D. Hylton, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Ann E. Felicia Slusher</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>219-03-5101A</b>		17. INFORMANT <b>Mrs. Ann H. Disharoon (Mother)</b> <b>311 Locust Terrace, Salisbury, Maryland</b>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Hypertensive C.V. Disease</b> DUE TO <b>Hypertensive C.V. Disease</b> (c) <b>Hypertensive C.V. Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Off</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		M.D.		22. DATE SIGNED <b>Feb. 22 1967</b>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>409 Camden Ave., Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 23, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>			25a. REC'D BY REGISTRAR <b>FEB 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

02886		MARYLAND STATE DEPARTMENT OF HEALTH		Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
Items 11, 12, 13, 14 Film G 336		CERTIFICATE OF DEATH		02876	
3/13/67 jml					
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Addie Jackson</b>		4. DATE OF DEATH Month Day Year <b>February 12 1967</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-05-22</b>	9. AGE (in years last birthday) <b>44</b> yrs	10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Hebron, Md.</b>	
13. FATHER'S NAME <b>Will Hayward</b>		14. MOTHER'S MAIDEN NAME <b>Nettie Custis</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>171X</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Metastatic Cx</b> DUE TO (c) <b>Leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/24/67</b> , 19 <b>67</b> to <b>2/12/67</b> , that (I) (we) last saw the deceased alive on <b>2/12/67</b> , 19 <b>67</b> , and that death occurred at <b>1240</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Heiko Baumann</b> M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>HEIKO BAUMANN</b>		22d. ADDRESS <b>P.O. Box 15</b>			
23a. BURIAL CREMATION <b>BURIAL</b> (Specify)		23b. DATE THEREOF <b>2/15/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pikes Road</b>	
23d. LOCATION (City or town) (County) (State) <b>Salisbury Wic Md</b>					
24. FUNERAL DIRECTOR <b>Brother M. West, Salisbury</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>MAR 7 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





FOR STATE  
HEALTH DEPT.

02885

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02877

1 PLACE OF DEATH a COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Wicomico</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c LENGTH OF STAY IN 1b <u>Parsonsbury</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Peninsula General Hospital</u>		e STREET ADDRESS <u>Box 165</u>	
3 NAME OF DECEASED (Type or print) <u>Debra</u> <u>MADINE</u>		4 DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>67</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>AA</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-21-60</u>
9 AGE (in years last birthday) <u>6</u> yrs		10 FUND 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Whaleyville, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>SEAMAN JONES</u>		14 MOTHER'S MAIDEN NAME <u>Shirley EVERETT</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>Shirley Jones</u>		Address <u>Parsonsbury Md.</u>	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture dislocation of the cervical spine</u>			
8124 DUE TO (b) _____			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) DUE TO _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Hit by car as she ran across road.</u>	
20c TIME OF INJURY Month, Day, Year <u>7:15</u> <u>2-3-67</u> <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Route 316</u>	20f (City or town) (County) (State) <u>Parsonsbury, Wicomico, Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		22. DATE SIGNED <u>February 7, 1967</u>	
EXAMINER'S NAME (Type) <u>1109 Camden Ave., Salisbury, Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPT. MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Parsonsbury, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>2-8-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>GREEN HILLS MEM. PK.</u>	23d LOCATION (City or town) (County) (State) <u>Salisbury Wico. Md.</u>
24 FUNERAL DIRECTOR <u>Jolley Funeral Home, Salisbury, Md.</u>		25a REC'D BY REGISTRAR <u>FEB 14 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

02886

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02878

1 PLACE OF DEATH a COUNTY <b>WICOMICO</b> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b> c LENGTH OF STAY IN lb <b>5 MO.</b> d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PENINSULA GENERAL HOSPITAL</b>		2 USUAL RESIDENCE (Where deceased lived f institution Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>WICOMICO</b> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b> d STREET ADDRESS <b>407 CAMDEN AVE.</b> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>GERALD</b> First Middle ***** Last <b>KING</b>		4 DATE OF DEATH <b>Feb. 4 1967</b> Month Day Year	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 26, 1923</b> 9 AGE (In years less than day) <b>43</b> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Pharmacy</b>	11 BIRTHPLACE (State or foreign country) <b>Ohio</b>
12 CITIZEN OF WHAT COUNTRY <b>USA</b>		13 FATHER'S NAME <b>Willard King</b>	
14 MOTHER'S MAIDEN NAME <b>Alice Lazette</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W War 2</b>	
16 SOCIAL SECURITY NO <b>262.24.9494</b>		17 INFORMANT <b>Wife: Mrs. Glova King</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute pyelonephritis of right kidney, severe</b> DUE TO (b) <b>Pseudomonas aeruginosa</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>chronic</b> (c) <b>Bronchopneumonia, bilaterally, early</b>		INTERVAL BETWEEN ONSET AND DEATH <b>two weeks</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)		20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Stephen Tynkiw</b> M.D.		22. DATE SIGNED <b>2-4-67</b>	
EXAMINER'S NAME (Type) <b>Stephen Tynkiw, M.D.</b>		DEPT. MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>2/8/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>	
24 FUNERAL DIRECTOR <b>J.T. STANSBERRY 6411 Windsor Mill Rd.</b>		25a. REC'D BY REGISTRAR <b>FEB 8 1967</b> 25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02887					02879				
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b Adm. in 1b <b>1/30/67</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>					d. STREET ADDRESS <b>R.D. #1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>ELIZABETH</b> Last <b>LANDING</b>			4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>19 67</b>						
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 25, 1891</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>14</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (County & State, or foreign country) <b>Somerset County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>George Washington Basford</b>					14. MOTHER'S MAIDEN NAME <b>Druicilla Frances Revelle</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>216-48-5799</b>		17. INFORMANT (Address) <b>Miss Frances Landing (Daughter) R.D.#1, Cedar Lane, Salisbury, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>5321</b> DUE TO (b) <b>generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) <b></b>								INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>degenerative heart disease - Congestive heart failure</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>N/A</b>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 19 66</b> to <b>2/9 1967</b> , that (I) (we) last saw the deceased alive on <b>2/8 19 67</b> , and that death occurred at <b>9:55 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>E. M. Beardsley</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 10/1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. E. M. Beardsley</b>					22d. ADDRESS <b>207 Maryland Ave., Salisbury, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 12, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>			
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>FEB 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b></b>		



FOR STATE  
HEALTH DEPT

02888

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02880

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Reside here before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN TB <u>1 week</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. STREET ADDRESS <u>River Road</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>DAVID L. J. LEWIS</u>		4 DATE OF DEATH Month Day Year <u>2-13-67</u> 19 <u>67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-25-1875</u>
9 AGE (n years lost birthday) <u>21</u> yrs		IF UNDER 1 YEAR Months Days Hours Min <u>21</u> yrs	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ships Master</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipping</u>	
11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Rev. Joseph Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Whealton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>--</u>		16. SOCIAL SECURITY NO <u>180-12-3438</u>	
17. INFORMANT <u>Mrs H. Victor Keen, Pocomoke City, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Advanced ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Minutes</u> <u>Years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Squamous carcinoma of mouth</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Died during surgery for squamous carcinoma of mouth.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. If city or town (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>February 14, 1967</u>	
ACTUAL SIGNATURE <u>Earl L. Royce, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>109 Camden Ave., Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-16-1967</u>	
23c. NAME OF CEMETERY <u>First Baptist</u>		23d. LOCATION (City or town) (County) (State) <u>Pocomoke City Wor. Md.</u>	
24. FUNERAL DIRECTOR <u>Robert W. Wagon</u>		ADDRESS <u>Pocomoke Funeral Home, Pocomoke, Md.</u>	
25a. RECD BY REGISTRAR DATE <u>FEB 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





02889

## CERTIFICATE OF DEATH

02881

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>12 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Pocomoke City</b> d. STREET ADDRESS <b>R.F.D. 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>LIDA ALICE MADDOX</b> First Middle Last		4 DATE OF DEATH Month Day Year <b>FEBRUARY 20 1967</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 9, 1892</b>
9 AGE (In years last birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (Country & State or foreign country) <b>Worcester County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Watson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Powell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Helen Maddox, Pocomoke City, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Anteroselective Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>1 day + 12 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I(a) <b>Anteroselective Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 18, 1967</b> , to <b>Feb 20, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb 20, 1967</b> , and that death occurred at <b>9:30 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>David J. Gilmore</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>David J. Gilmore, M.D.</b>		22d. ADDRESS <b>Medical Center, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-23-1967</b>	23c. NAME OF CEMETERY <b>First Baptist</b>	23d. LOCATION (City or Town) (County) (State) <b>Pocomoke City Wor. Md.</b>
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or interment, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>						d. STREET ADDRESS <b>606 Waverly Street</b>					
3. NAME OF DECEASED (Type or print) First <b>MAY</b> Middle <b>REGINA</b> Last <b>MINOGUE</b>						4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 26, 1899</b>		9. AGE (in years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-Wife &amp; teacher (Retired) School</b>						10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Quinlan</b>						14. MOTHER'S MAIDEN NAME <b>Mary Kennedy</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Mr. Edward A. Minogue (Husband)</b> <b>606 Waverly Street, Salisbury, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism &amp; Infarction</b> <b>461 X</b> DUE TO (b) <b>Phlebotrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis &amp; Splenic Artery Thrombosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b></b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>N/A</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>		20g. (City or town) (County) (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1-31-1967</b> to <b>2-3-1967</b> that (I) (we) last saw the deceased alive on <b>2-1-1967</b> , and that death occurred at <b>8:25M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>James L. Clifford</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Feb. 3, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. James L. Clifford</b>						22d. ADDRESS <b>Medical Center, Salisbury, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Feb. 6, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore County, Maryland</b>			
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>FEB 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b></b>			



02891

## CERTIFICATE OF DEATH

02883

1 PLACE OF DEATH a COUNTY <u>Wicomico</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c LENGTH OF STAY IN 1b <u>2</u>		2 USUAL RESIDENCE (Where deceased lived, if institution, give institution) a STATE <u>MARYLAND</u> b COUNTY <u>Wicomico</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d STREET ADDRESS <u>23 Bay Street</u>	
3 NAME OF DECEASED (Type or print) <u>Hubert Mac Munnick</u>		4 DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 1, 1911</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11 BIRTHPLACE (County & State or foreign country) <u>Wilmington, DE</u>
13 FATHER'S NAME <u>David Rose</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth Howard</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>25-12-6171</u>	17 INFORMANT <u>Elizabeth Howard</u>
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5271</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>with chronic COPD</u> DUE TO (c) <u>Pulmonary Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>2/18</u> , 19 <u>67</u> , to <u>2/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/26</u> , 19 <u>67</u> , and that death occurred at <u>8:00</u> A.M. from causes and on the date stated above.			
22a SIGNATURE <u>David J. Gilmore</u>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>2/26/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>	23d LOCATION (City or Town) (County) (State) <u>Salisbury, Wicomico, MD</u>
24 FUNERAL DIRECTOR <u>Charles Judge</u>		25a REC'D BY REGISTRAR DATE <u>FEB 28 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The deceased remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02892

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02884

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. STREET ADDRESS <b>516 E. Locust Street</b>	
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>ANNETTE</b> Last <b>MYERS</b>		4. DATE OF DEATH <b>February 4, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 10, 1914</b>
9. AGE (In years last birthday) <b>52</b> yrs		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>24</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Jacksonville, Florida</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ralph Carter</b>		14. MOTHER'S MAIDEN NAME <b>(Unk.)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>541-34-5906</b>	
17. INFORMANT <b>Mr. John E. Myers (Husband)</b>		Address <b>516 E. Locust Street, Salisbury, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO <b>multiple fractures</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by truck crossing Hwy</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:30 AM. 1-11-67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home form, factory, street, place of b.d., etc.) <b>Rt 13</b>		20f. (City or town) <b>Salisbury</b> (County) <b>Wicomico</b> (State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>February 6, 1967</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 8, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellow Cemetery</b>		23d. LOCATION (City or Town) <b>Laurel, Delaware</b> (County) <b></b> (State) <b></b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 8 1967</b>	





FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 157  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02893

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02885

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Peninsula General Hospital</b>				a. STREET ADDRESS <b>348 Cedar Drive</b>			
3 NAME OF DECEASED (Type or print) First <b>LUCILLE</b> Middle <b>E.</b> Last <b>NICHOLAS</b>				4 DATE OF DEATH Month <b>2-19-67</b> Day <b>19</b> Year <b>19</b>			
5 SEX <b>F</b>	6 COLOR OR RACE <b>AA</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2-10-1912</b>		9 AGE (In years last birthday) <b>55</b> yrs		10 UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>12</b> Min <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11 BIRTHPLACE (State or foreign country) <b>Penn.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Perry Dutton</b>				14 MOTHER'S MAIDEN NAME <b>Mary W. Nichols</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT <b>Ethel Gale - Fruitland, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO (b) <b>Acute congestive heart failure</b> DUE TO (c) <b>Acute congestive heart failure</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), LISTING THE UNDERLYING CAUSE <b>4.5.41</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Hours</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b> EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>				22. DATE SIGNED <b>February 23, 1967</b>			
23a. BURIAL (CREMATION REMOVAL) (Specify)		23b. DATE THEREOF <b>2-25-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>		23d. LOCATION (City or town) (County) (State) <b>Salisbury, Md. Wicomico</b>	
24 FUNERAL DIRECTOR <b>Jolley Funeral Home, Salisbury, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02894

## CERTIFICATE OF DEATH

02886

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>3 Wks.</u>		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institut an- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Parker Rd., Rt. #5</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>MAMIE HOLLOWAY PARKER</u>		<b>4 DATE OF DEATH</b> Month Day Year <u>2 28 19 67</u>	
<b>5 SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Oct. 11, 1893</u>
<b>9 AGE</b> (In years last birthday) yrs <u>73</u>		<b>10a USUA. OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
<b>10b KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11 BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland, Wicomico</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Elisha Holloway</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Jackson</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
<b>16 SOCIAL SECURITY NO.</b> <u>214-28-7952</u>		<b>17 INFORMANT</b> Address <u>Mrs. Thomas Mumford, Sec. 2</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO (b) <u>Phlebotrombosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Idiopathic Thrombocytopenic Purpura</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	
<b>20d INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb. 8, 1967</u> , to <u>Feb 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 28, 1967</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.	
<b>22a SIGNATURE</b> <u>Thomas C Hill Jr.</u>		<b>22b. DATE SIGNED</b> <u>3/2/67</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Thomas C Hill Jr.</u>		<b>22d. ADDRESS</b> <u>Pine Bluff Road, Salisbury, Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3-2-1967</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Wicomico Memorial Park</u>		<b>23d. LOCATION</b> (City or Town) (County) (State) <u>Salisbury, Maryland</u>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Hill Funeral Home Salisbury, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 6 1967</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02895

## CERTIFICATE OF DEATH

02887

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Dorchester</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>						d. STREET ADDRESS <b>Taylor Avenue</b>					
3 NAME OF DECEASED (Type or print) First Middle Last <b>Velma Hercelia Payne</b>						4. DATE OF DEATH Month Day Year <b>February 1 19 67</b>					
5 SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 13, 1907</b>		9 AGE (In years last birthday) <b>59 yrs</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Caroline Co., Maryland</b>			12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Minos Cohee</b>						14. MOTHER'S MAIDEN NAME <b>Katie Robinson</b>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-07-8649</b>		17. INFORMANT Address <b>Mrs. Charlotte Hearne, Secretary, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. <b>4331</b> IMMEDIATE CAUSE (a) <b>Cardiac fibrillation.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 31, 1967</b> to <b>Feb 1, 1967</b> that (I) (we) lost saw the deceased alive on <b>Feb 1, 1967</b> and that death occurred at <b>8:17</b> M, from causes and on the date stated above.											
22a. SIGNATURE <b>Youngs Moon</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb 1, 1967</b>					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Feb. 4, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Williamsburg, Maryland</b>			
24 FUNERAL DIRECTOR <b>J. O. Frampton and Son, Federalburg, Maryland</b>						ADDRESS		25a. REC'D BY REGISTRAR DATE <b>FEB 7 1967</b>			
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02896

CERTIFICATE OF DEATH

02888

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN TB		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Wicomico</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PITTSVILLE</b>		d. STREET ADDRESS <b>RT.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Lelia Pennewell</b>		4 DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1967</b>		5 SEX <b>Female</b>		6 COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH		9 AGE (n years last birthday) <b>53 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life even retired) <b>Life Insurance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Life Insurance</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mississippi</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James Pennewell</b>		14 MOTHER'S MAIDEN NAME <b>Beatrice Pennewell</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO. <b>215-26-4054</b>		17. INFORMANT <b>Mrs. Ruth Jones</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO (b) <b>Stroke</b> DUE TO (c) <b>Heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>2-3</b> , 19 <b>67</b> to <b>2-4</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>2-4</b> , 19 <b>67</b> , and that death occurred at <b>Pittsville, Md.</b> from causes and on the date stated above.		22a. SIGNATURE <b>W. B. Bell</b>		22b. DATE SIGNED <b>2-4-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/7/67</b>		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City or Town) (County) (State) <b>PITTSVILLE WIC. MD</b>		24. FUNERAL DIRECTOR <b>James P. Jones</b>		24a. ADDRESS		24b. REC'D BY REGISTRAR DATE <b>FEB 8 1967</b>		24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		24d. ADDRESS		24e. DATE	

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02897

CERTIFICATE OF DEATH

02889

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN IS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>700 E. Church Street</b>	
3 NAME OF DECEASED (Type or print) <b>CRESTON</b>		First <b>ARRILUS (RILL)</b>		Last <b>POLLITT</b>	
4 DATE OF DEATH <b>February 3</b>		Month <b>1967</b>		Day <b>3</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Nov. 5, 1877</b>	9 AGE (In years last birthday) <b>89</b> yrs.	10 UNDER 1 YEAR Months <b>2</b> Days <b>28</b> Hours <b></b> Mins <b></b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Wicomico County, Maryland USA</b>	
13 FATHER'S NAME <b>Joshua D. Pollitt</b>			14 MOTHER'S MAIDEN NAME <b>Charlotte Ellen Maddox</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>215-26-4408 A</b>		17 INFORMANT <b>Mrs. Irma Kieffer &amp;/or Mrs. Naomi Long, Salisbury, Maryland</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic coronary artery disease</b> DUE TO (c) <b>known</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/26/67</b> to <b>2/3/67</b> that (I) (we) last saw the deceased alive on <b>2/3/67</b> and that death occurred at <b>7:45 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>[Signature]</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 3 / 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. D. J. Burton</b>		22d. ADDRESS <b>Medical Center, Salisbury, Maryland</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Feb. 6, 1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	
23d LOCATION (City or Town) <b>Salisbury, Maryland</b>		23e (County)		23f (State)	
24 FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		ADDRESS		25a-REC'D BY REGISTRAR <b>FEB 6 1967</b>	
25b REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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02898

## CERTIFICATE OF DEATH

02890

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN lb <b>1 Day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden #1</b> d. STREET ADDRESS <b>Meadow Bridge Rd.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First Middle Last <b>RAYMOND</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 7 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1873</b>
9. AGE (In years last birthday) <b>94</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Brooklyn, N.Y.</b>
12. CITIZEN OF WHAT COUNTRY? A. <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward Raymond</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown Hall</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Mr. John Raymond Grace St. Salisbury, Md.</b>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Viral Encephalitis</b> DUE TO <b>Dehydration</b> (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>Second day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 17, 1966</b> to <b>Feb. 7, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb. 6, 1967</b> , and that death occurred at <b>5 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>G. Herbert Seably</b> M.D.		22b. DATE SIGNED <b>2/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. Herbert Seably</b>		22d. ADDRESS <b>Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-9-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Eden, Wicomico, Maryland</b>
24. FUNERAL DIRECTOR <b>Hill Funeral Home Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

BP

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02899						02891					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
a. COUNTY <i>Wicomico</i>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			a. STATE <i>Maryland</i>			b. COUNTY <i>Wicomico</i>		
c. LENGTH OF STAY IN 1b <i>3 days</i>			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Wicomico Nursing Home</i>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Willards, RFD.</i>			d. STREET ADDRESS <i>Booth Street</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. AGE (In years last birthday)		
First <i>Rayce</i>			Middle <i>Little</i>			Last <i>Chelene</i>			Month <i>February</i>		
Day <i>3</i>			Year <i>1967</i>			6. COLOR OR RACE <i>W</i>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		
8. DATE OF BIRTH <i>8/25/88</i>			9. AGE (In years last birthday) <i>78</i> yrs.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>Jackson Lee Dennis</i>			14. MOTHER'S MAIDEN NAME <i>Cinnie Jane Powell</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>X</i>			16. SOCIAL SECURITY NO. <i>212-10-9101</i>			17. INFORMANT <i>Alvin Dennis</i>			Address <i>Willards, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <i>Cerebral Arteriosclerosis</i>								
(c)			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		
Hour <i>a.m.</i>			Month <i>Jan.</i>			Day <i>2</i>			Year <i>1967</i>		
p.m. <i>19</i>			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 2, 1967</i> to <i>Feb. 3, 1967</i> , that (I) (we) last saw the deceased alive on <i>Feb 3, 1967</i> , and that death occurred at <i>2 P</i> M, from the causes and on the date stated above.			22a. SIGNATURE <i>Walter J. Whaley</i>			22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		
						23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Pleasant</i>			23d. LOCATION (City, town or county) (State) <i>Willards, Md.</i>		
24. FUNERAL DIRECTOR <i>Walter Whaley</i>			25a. REC'D BY REGISTRAR <i>Charles Judge</i>			25b. REGISTRAR'S SIGNATURE			DATE <i>FEB 8 1967</i>		



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02900

## CERTIFICATE OF DEATH

02892

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>30 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>301 Maryland Ave.,</u>				d. STREET ADDRESS <u>301 Maryland Ave.,</u>		e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mollie Driscoll Rayne</u>				4. DATE OF DEATH Month Day Year <u>2 27 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 18, 1897</u>	
				9. AGE (In years last birthday) yrs <u>69</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>                    </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico-Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elijah Driscoll</u>				14. MOTHER'S MAIDEN NAME <u>Ada Gertrude Evans</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>220-32-1232</u>		17. INFORMANT Address <u>S.W. Rayne, Jr Salisbury, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable Acute Myocardial Infarction</u> DUE TO (b) <u>Coronary Heart Failure</u> DUE TO (c) <u>Atherosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cystitis - acute</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-23</u> , 19 <u>67</u> , to <u>2-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-23</u> , 19 <u>67</u> , and that death occurred at <u>11 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Thomas P. Bigbee</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas P. Bigbee</u> M.D.				22d. ADDRESS <u>211 Maryland Ave., Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/2/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>Hill Funeral Home</u> <u>Salisbury, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





02901

## CERTIFICATE OF DEATH

02893

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Salisbury</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie C Rhodes</u>		4. DATE OF DEATH Month Day Year <u>February 23 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years last birthday) <u>82 yrs.</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Accomack Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter W. Ponniwell</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Interosse Myocardial Infarction</u> DUE TO <u>Thrombocytopenia</u> (b) <u>Occlusion of Descending Coronary artery, Left</u> DUE TO <u>Arteriosclerosis Heart &amp; Kidney</u> (c) <u>Arteriosclerosis Heart &amp; Kidney</u> INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cephalo, Renal</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/5</u> , 19 <u>67</u> , to <u>2/23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/23</u> , 19 <u>67</u> , and that death occurred at <u>4:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Rufus S Gardner Jr</u>		22b. DATE SIGNED <u>2/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RUFUS SGARDNER JR</u>		22d. ADDRESS <u>MEDICAL CENTER, SALISBURY MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Drewer</u>	23d. LOCATION (City or Town) (County) (State) <u>Salisbury - Accomack Co.</u>
24. FUNERAL DIRECTOR <u>James H. Fox</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 2 1967</u>	
ADDRESS <u>Temperanceville, Va</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02902

CERTIFICATE OF DEATH

02894

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN Tb <b>1 day.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b> d. STREET ADDRESS <b>—</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>KATIE RICKARDS</b> f. SEX <b>FEMALE</b> g. COLOR OR RACE <b>White</b> h. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> i. DATE OF BIRTH <b>OCT. 28, 1875</b> j. AGE (in years last birthday) <b>91</b> yrs k. IF UNDER 1 YEAR Months Days l. IF UNDER 24 HRS Hours Min		4. DATE OF DEATH <b>FEBRUARY 23</b> 19 <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11 BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13 FATHER'S NAME <b>James Smith</b>		14 MOTHER'S MAIDEN NAME <b>Northa Murray</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>X X X</b>		16 SOCIAL SECURITY NO <b>214-36-5083</b>	
17 INFORMANT <b>Raymond Hudson Bishopville, Md.</b>		18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Atherosclerotic coronary artery disease</b> DUE TO (c) <b>hypertensive heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>hypertensive heart disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/22/67</b> to <b>2/23/67</b> , that (I) (we) last saw the deceased alive on <b>2/23/1967</b> , and that death occurred at <b>2:45</b> A.M. from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/26/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>L.O.O.F.</b>		23d. LOCATION (City or Town) (County) (State) <b>Bishopville, Md.</b>	
24. FUNERAL DIRECTOR <b>Walter W. Haley, Bishopville, Md.</b>		25a. REC'D BY REGISTRAR <b>[Signature]</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		DATE <b>FEB 27 1967</b>	



02903

## CERTIFICATE OF DEATH

02895

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>PRINCESS ANNE</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>16</b>	
3. NAME OF DECEASED (Type or print) <b>John D. RIDGWAY</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>18</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/24/1899</b>
9 AGE (in years last b. day) <b>67</b> yrs		10. IF UNDER 18 Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED BUILDER CONTRACTOR</b>		10b KIND OF BUSINESS OR INDUSTRY <b>CONTRACTOR</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>WESTCHESTER, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W. RIDGWAY</b>		14. MOTHER'S MAIDEN NAME <b>BESSIE PASSMORE</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>WAR 1</b>		16 SOCIAL SECURITY NO. <b>165-28-9810A</b>	
17 INFORMANT <b>MRS LILLIAN RIDGWAY PRINCESS ANNE, MD</b>		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4200</b> IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic Heart disease</b> (c) <b>calcium</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>2-10, 1967</b> to <b>2-18, 1967</b> , that (I/we) last saw the deceased alive on <b>2-18, 1967</b> and that death occurred at <b>8:00</b> M, from causes and on the date stated above.			
22a SIGNATURE <b>Levin R. Wilson</b>		22b. DATE SIGNED <b>2-18-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>2/22/1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>HIGHLAND MEMORIAL PARK POTTSTOWN, PA.</b>	23d LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>LEVIN R. WILSON PRINCESS ANNE, MD.</b>		25a REC'D BY REGISTRAR <b>FEB 21 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

- f -

02904

CERTIFICATE OF DEATH

02896

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only seven days within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb. <u>ATLANTIC</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomack</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ATLANTIC</u> d. STREET ADDRESS <u>Box #139</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELLEN</u> First <u>MAE</u> Middle <u>ROGERS</u> Last S. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>NOV. 23, 1906</u> 9. AGE (In years last birthday) <u>0</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>2</u> Hours <u>19</u> Min. <u>67</u>		4. DATE OF DEATH <u>FEBRUARY 24</u> 19 <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GERALD ROGERS</u> 14. MOTHER'S MAIDEN NAME <u>BETTY TROUT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO <u>None</u> 17. INFORMANT <u>GERALD ROGERS, ATLANTIC, VA.</u> Address <u>Box #139</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Disseminated Intracerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerosis and Aneurysm</u> DUE TO (c) <u>Hypertension, renal, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>approx 74 hrs</u> <u>3 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>2/23/67</u> , 19 <u>67</u> , to <u>2/24/67</u> , that (1) (we) last saw the deceased alive on <u>2/24/67</u> , and that death occurred at <u>1:12</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred C. Koles</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Medical Center, Salisbury, Md</u>		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/26/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CHRISTIAN</u>	23d. LOCATION (City or Town) (County) (State) <u>Snow Hill, MD</u>
24. FUNERAL DIRECTOR <u>Edward E. Snow</u> ADDRESS <u>Snow Hill, MD</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 28 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>





02905

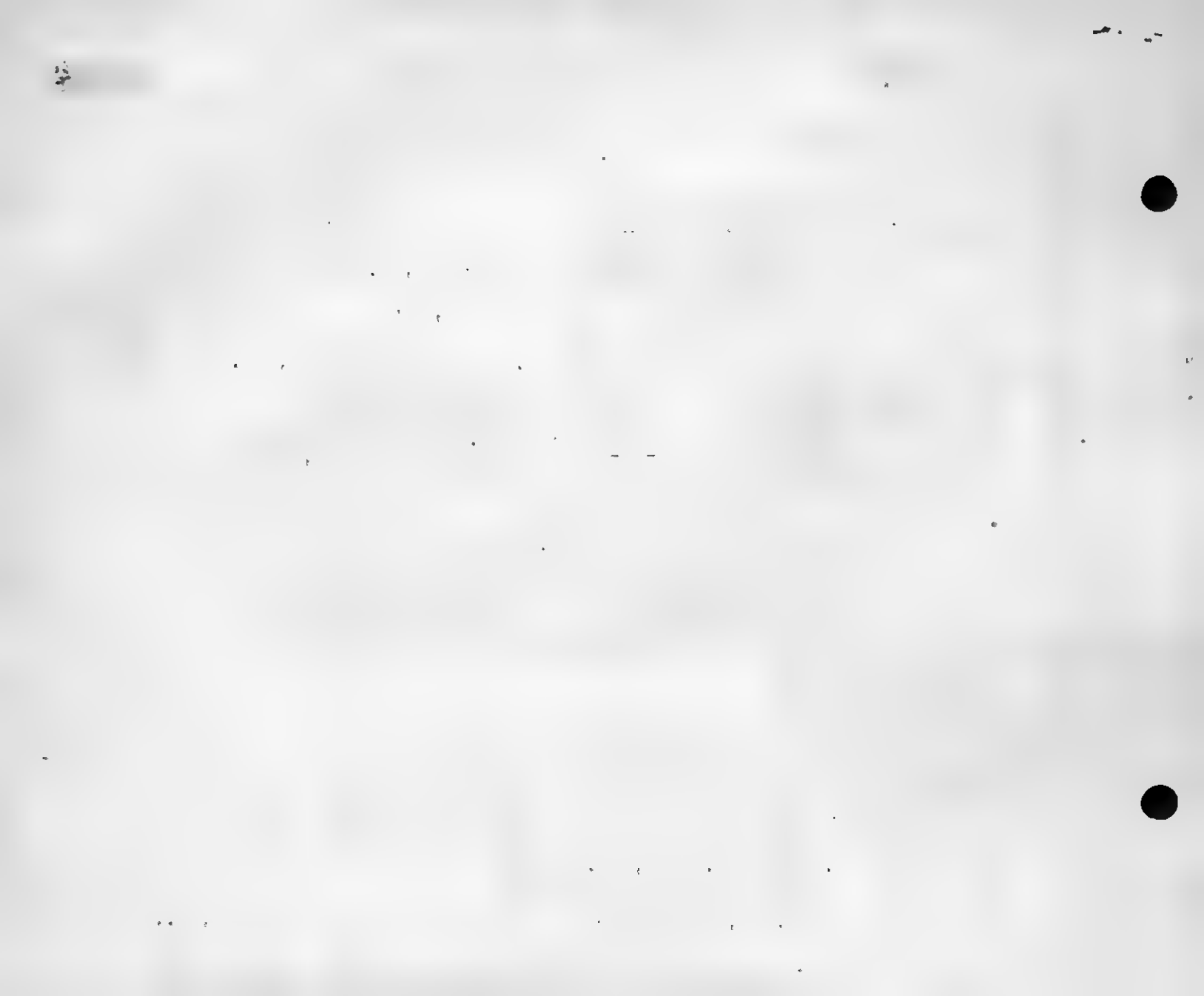
## CERTIFICATE OF DEATH

02897

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY in 1b <b>Adm. in 1b 2/8/67</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		d. STREET ADDRESS <b>511 Regency Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>RAYMOND SAMUEL</b>		First Middle Last <b>SMACK, Sr.</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 21 19 67</b>		5 SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 AGE (In years last birthday) <b>53 yrs</b>		9 AGE (In years last birthday) <b>53 yrs</b>		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Roads Comm.</b>		11. BIRTHPLACE (County & State or foreign country) <b>Worcester County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>William Smack</b>		14 MOTHER'S MAIDEN NAME <b>Susan Butler</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes War II</b>		16. SOCIAL SECURITY NO. <b>220-36-8229</b>		17. INFORMANT <b>Mrs. Norma Lee Smack (Wife)</b> <b>511 Regency Drive, Salisbury, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC Heart Disease</b> (c) <b>HYPERTENSION and Diabetes</b>	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes War II</b>		20. SOCIAL SECURITY NO. <b>220-36-8229</b>		21. BIRTHPLACE (County & State or foreign country) <b>Worcester County, Md.</b>		22. CITIZEN OF WHAT COUNTRY? <b>USA</b>		23. FATHER'S NAME <b>William Smack</b>		24. MOTHER'S MAIDEN NAME <b>Susan Butler</b>	
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>		27. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		28. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		29. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		30. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 8, 1967</b> to <b>Feb 21, 1967</b> that (I) (we) last saw the deceased alive on <b>Feb 20, 1967</b> , and that death occurred at <b>7:54 A.M.</b> from causes on and on the date stated above.		22a. SIGNATURE <b>Thomas C. Hill Jr.</b>		22b. DATE SIGNED <b>Feb 21, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas C. Hill, Jr.</b>		22d. ADDRESS <b>PINE BLUFF Rd., SALISBURY MD</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>Feb. 23, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Nelson Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Accomac Co., Virginia</b>		24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02906

## CERTIFICATE OF DEATH

02898

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN b <b>16</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Worcester</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wicomico Nursing Home</b>						d. STREET ADDRESS <b>Washington St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY V SMITH</b>						4. DATE OF DEATH <b>Feb. 27 19 67</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 13, 1886</b>		9. AGE (In years last birthday) yrs <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Elijah Perdue</b>						14. MOTHER'S MAIDEN NAME <b>Margaret Sturgis</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-22-6779</b>		17. INFORMANT <b>Mrs. Virginia M. Seipp La Crescenta</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>332X Immediate Cause (a) Arterial Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/24, 1967</b> to <b>2/27, 1967</b> , that (I) (we) last saw the deceased alive on <b>2/26, 1967</b> , and that death occurred at <b>5:14 A.M.</b> , from causes and on the date stated above.											
22a. SIGNATURE <b>Earl M. Beardsley</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/27/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Earl M. Beardsley</b>						22d. ADDRESS <b>Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/1/1967</b>		23c. NAME OF CEMETERY OR CREMATOR <b>All Hallows Episcopal</b>				23d. LOCATION (City or Town) (County) (State) <b>Snow Hill, Md.</b>			
24. FUNERAL DIRECTOR <b>Charles Judge</b>						25a. REC'D BY REGISTRAR <b>DATE MAR 2 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

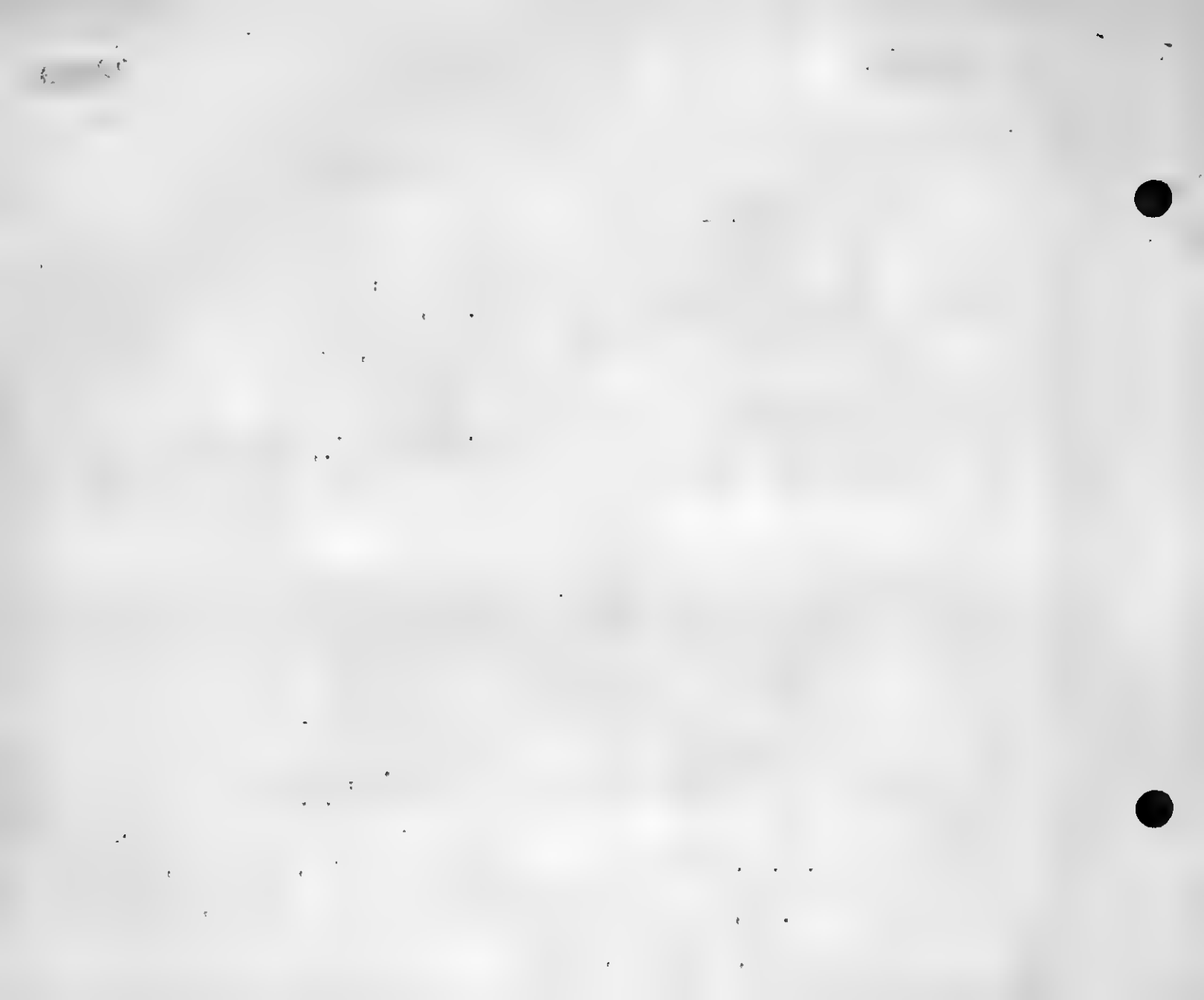
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If you please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
02907					02899					
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>					d. STREET ADDRESS <b>15 Calhoun Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF <b>DECEASED</b> (Type or print) <b>TODD STEWART SMITH</b>			First Middle Last		4. DATE DEATH <b>February 14 1967</b>		Month Day Year		5. SEX <b>Male</b>	
5. SEX	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> Baby <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 13, 1967</b>		9. AGE (In years last birthday) <b>0</b> yrs.		IF UNDER 1 YEAR Months Days Hours Mins.	IF UNDER 24 HRS. Months Days Hours Mins.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Salisbury, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Preston Randle Smith</b>					14. MOTHER'S MAIDEN NAME <b>Polly Mae Stewart</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. (If give war or dates of service)		17. INFORMANT <b>Mr. Preston R. Smith (Father)</b> <b>15 Calhoun Ave., Salisbury, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perinatal asphyxia, aspiration of fluid</b> 7610 DUE TO (b) <b>Prolapsed cord</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Premature separation of membranes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>2 hr 45</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from <b>2/13</b> <b>App.</b> 19 <b>67</b> , to <b>2/14</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/14</b> 19 <b>67</b> , and that death occurred at <b>12:10</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>D. B. Anderson</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 16/1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. D. G. Anderson</b>					22d. ADDRESS <b>Medical Center, Salisbury, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 16, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>				
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>Feb 20 1967</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02908

## CERTIFICATE OF DEATH

02900

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>Salisbury</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>408 Winder Street</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>408 Winder Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LESTER</b> Middle <b>MARTIN</b> Last <b>STEELE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 25, 1902</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b>		11. IF UNDER 24 HRS. Days <b>7</b>		12. IF UNDER 24 HRS. Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dispatcher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Power &amp; Light Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Lewes, Delaware</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Elmer Steele</b>				14. MOTHER'S MAIDEN NAME <b>Eunice Spicer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>				16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Mrs. Bernice W. Steele (Wife)</b> <b>408 Winder Street, Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1947</b> , 19 <b>2-2-67</b> , to <b>2-2-67</b> , 19 <b>2-2-67</b> , that (I) (we) last saw the deceased alive on <b>2-31-67</b> , 19 <b>2-31-67</b> , and that death occurred at <b>2P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Lee L. Lawry</b>				22b. DATE SIGNED <b>Feb. 3 / 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lee L. Lawry</b>				22d. ADDRESS <b>315 N. Division St., Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 5, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>FEB 6 1967</b>			
				25b. REGISTRAR'S SIGNATURE <b>Orles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

02903

02901

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN TB c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLSBORO</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>JANNIE STEPHENS</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>FEBRUARY 1 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1886</u>
9. AGE (In years last birthday) <u>80 yrs.</u>		10. F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (County & State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CLAYTON ATKINS</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH ATKINS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>222-01-7286</u>	
17. INFORMANT <u>MRS. DALLAS HUDSON, MILLSBORO</u>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable pulmonary infarction</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Deep vein thrombosis of left lower extremity</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease - hypertensive</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Suspect neoplasm of lung</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-12-</u> , 19 <u>67</u> , to <u>2-1,</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-31</u> , 19 <u>67</u> , and that death occurred at <u>7:20</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>James L. Clifford</u> M.D.		22b. DATE SIGNED <u>2-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES L. CLIFFORD</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MILLSBORO CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>MILLSBORO, DESS, DEL.</u>
24. FUNERAL DIRECTOR <u>A. Douglas Melton</u>		ADDRESS <u>Frankford, Del.</u>	
25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02910

# CERTIFICATE OF DEATH

02902

1. PLACE OF BIRTH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>Salisbury</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>432 Druid Hill Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR F. STRAN</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>9</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-19-1892</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. UNDER 1 YEAR Months <b>14</b> Days <b>14</b>	11. UNDER 24 HRS. Hours <b>14</b> Min <b>14</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocery Business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry P. Stran</b>	
14. MOTHER'S MAIDEN NAME <b>Alverda Rictor</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO <b>212-07-4289</b>		17. INFORMANT <b>Louise Stran-432 Druid Hill Ave. Salisbury</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart Disease</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>INTERVAL BETWEEN ONSET AND DEATH</b> (c) <b>MD</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-23-1967</b> to <b>2-9-1967</b> , that (I) (we) last saw the deceased alive on <b>2-9-1967</b> and that death occurred at <b>7 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>William R. [Signature]</b> M.D.		22b. DATE SIGNED <b>2-9-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-13-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Elburnth [Signature]</b>		25a. REC'D BY REGISTRAR <b>FEB 14 1967</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>
ADDRESS <b>4600 Liberty Hghts. Avenue</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1 (4)  
20 M 1/66



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02911

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02903

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Pittsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>SAMUEL</b> Last <b>TINDLE</b>		4 DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 30, 1895</b>
9 AGE (In years last birthday) <b>71 yrs</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11 BIRTHPLACE (State or foreign country) <b>Wicomico County, Md.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert R. Tindle</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Driscoll</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO <b>--</b>		17. INFORMANT <b>Mrs. Helen C. Tindle (Wife)</b> <b>R.D. #1, Pittsville, Maryland</b>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>5237</b> DUE TO <b>Fx Dorsal spine &amp; sacral cord</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of vehicle ran off road</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt 353</b>		20f. City or town (County) (State) <b>Pittsville Wicomico Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>February 3, 1967</b>	
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b> EXAMINER'S NAME (Type) <b>409 Camden Avenue, Salisbury, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 6, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Farlow Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Pittsville, Maryland</b>
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>FEB 6 1967</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02912											
02904											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN b. <b>Adm. in 1 D</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>711 Taylor Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>WASHINGTON</b> Last <b>TOWNSEND</b>						4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>19 67</b>					
5. SEX <b>Male</b>						6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 10, 1879</b>	
9. AGE (in years last birthday) <b>87</b> yrs.						10. IF UNDER 1 YEAR Months <b>6</b> Days <b>9</b>		11. IF UNDER 24 HRS. Hours <b>6</b> Min. <b>9</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Huckster</b>					
11. BIRTHPLACE (County & State, or foreign country) <b>Worcester County, Md.</b>						12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Robert Townsend</b>						14. MOTHER'S MAIDEN NAME <b>Margaret Butler</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>						16. SOCIAL SECURITY NO. <b>217-10-2126</b>					
17. INFORMANT <b>Mrs. Martha P. Townsend (Wife)</b> Address <b>711 Taylor Street, Salisbury, Maryland</b>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive infarct of L. Lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <b>Embolus L. Arm</b> <b>Arteriosclerosis (widespread)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Salisbury, Wicomico</b>						20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>2:55</b> p.m. <b>2:55</b>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Salisbury, Wicomico</b>					
20f. (City or town) <b>Salisbury</b>						20g. (County) <b>Wicomico</b>					
20h. (State) <b>MD</b>						20i. (City or town) <b>Salisbury</b>					
20j. (County) <b>Wicomico</b>						20k. (State) <b>MD</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>2/18/67</b> to <b>2/19/67</b> , that (I) (we) last saw the deceased alive on <b>2/18/67</b> , and that death occurred at <b>2:55</b> from the causes and on the date stated above.						22a. SIGNATURE <b>Carrie I. Hearn</b> M.D. <b>Dr. Carrie I. Hearn</b>					
22b. DATE SIGNED <b>Feb. 20/1967</b>						22c. PHYSICIAN'S NAME (Type) <b>Dr. Carrie I. Hearn</b>					
22d. ADDRESS <b>226 N. Division Street, Salisbury, Md.</b>						22e. REC'D BY REGISTRAR <b>Feb 21 1967</b>					
22f. REGISTRAR'S SIGNATURE <b>Charles J. Jago</b>						23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
23b. DATE THEREOF <b>Feb. 22, 1967</b>						23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>					
23d. LOCATION (City, town or county) <b>Salisbury, Maryland</b>						23e. (State) <b>MD</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>						24a. ADDRESS <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>					





02913

## CERTIFICATE OF DEATH

02905

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>Hoopersville</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>George W. TRAVERS</u>		4. DATE OF DEATH Month Day Year <u>February 27 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1904</u>
9 AGE (In years lost birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min <u>28</u> <u>27</u> <u>27</u> <u>27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilbert Travers</u>		14. MOTHER'S MAIDEN NAME <u>Delia Travers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-6254</u>	
17. INFORMANT <u>Flora L. Travers, Hoopersville, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO (b) <u>Carcinoma of Prostate</u> DUE TO (c) <u>17.1X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>1 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>--</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>February 21, 1967</u> , to <u>February 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>February 27, 1967</u> , and that death occurred at <u>1:55 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>C. H. Winnacott</u>		22b. DATE SIGNED <u>2-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. C. H. Winnacott</u>		22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/5/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cambridge, Maryland</u>	
24. FUNERAL DIRECTOR <u>Herbert M. Clark Jr.</u>		25a. REC'D BY REGISTRAR <u>Charles Jones</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		DATE <u>MAR 2 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02914

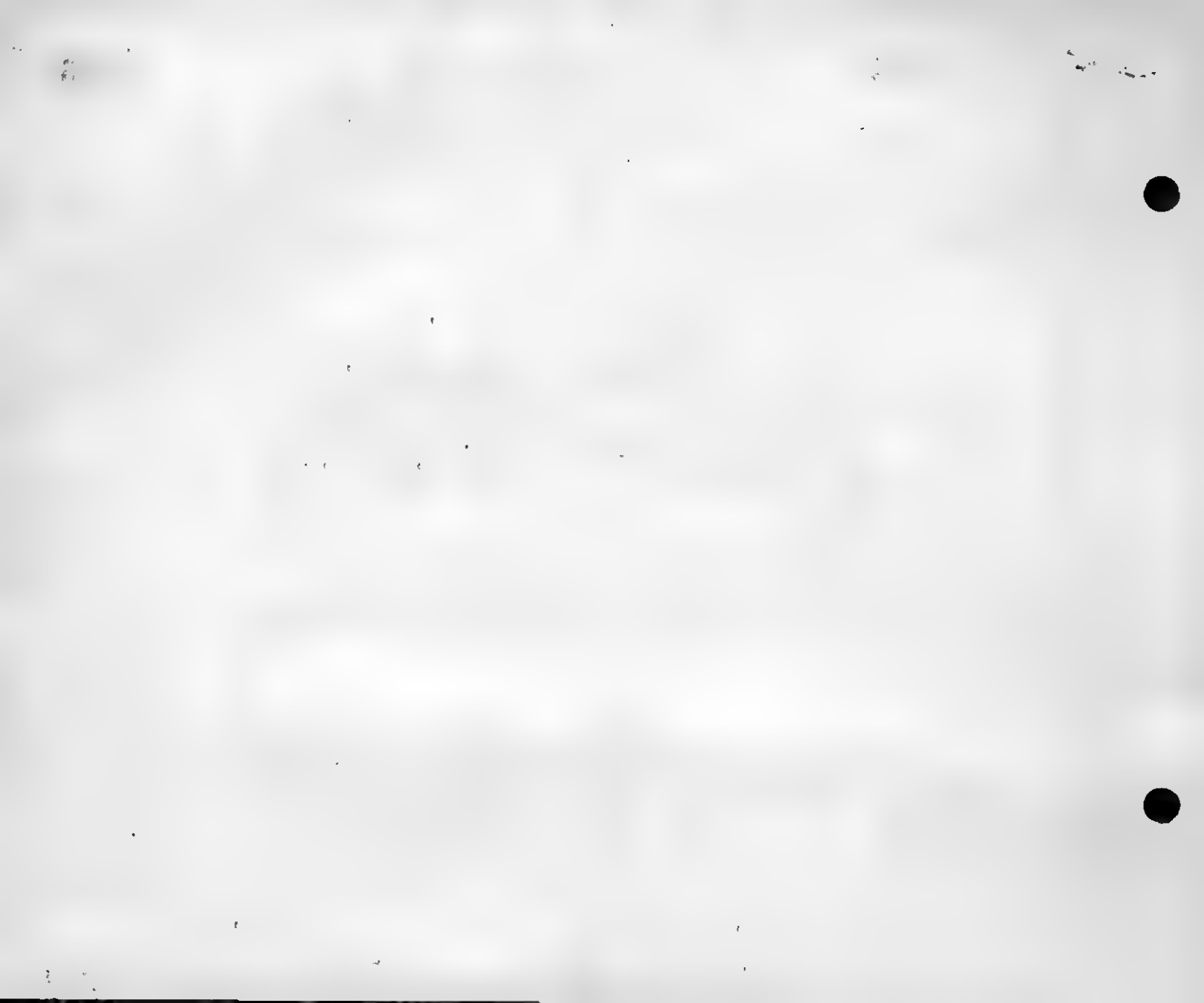
CERTIFICATE OF DEATH

02906

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>Adm. in 1D 1/14/67</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b> d. STREET ADDRESS <b>In Village</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Manie POLONIA</b>		4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1877</b>
9. AGE (in years last birthday) <b>89</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Employee</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shirt Factory</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Powellville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lambert Wilkins</b>		14. MOTHER'S MAIDEN NAME <b>Zenia Bradford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>220-52-8054</b>	
17. INFORMANT <b>Mrs. Mary Cathell (Daughter)</b> <b>Box 101, Berlin, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>332X Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 14, 1967</b> , to <b>Feb 25, 1967</b> , that (I) (we) last saw the deceased alive on <b>Feb 25, 1967</b> , and that death occurred at <b>2 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>David J. Gilmore</b>		22b. DATE SIGNED <b>Feb. 25/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>David J. Gilmore</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 1, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Willards Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Willards, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 28 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Items 6 &amp; 9 Filed 3/17/67 kx

02915

## CERTIFICATE OF DEATH

02907

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>Peninsula General Hospital</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>West Ocean City</b> d. STREET ADDRESS <b>Rt 41 Box 373</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>EMANUEL FRANCIS TYLER</b>		4 DATE OF DEATH Month <b>FEBRUARY</b> Day <b>23</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>AA</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3-18-1918</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11 BIRTHPLACE (County & State or foreign country) <b>Orangeburg S.C.</b>	
13. FATHER'S NAME <b>Prince Tyler</b>		14. MOTHER'S MAIDEN NAME <b>Geneva Thomas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>251-28-088</b>		17. INFORMANT <b>Estella Tyler - West Ocean City Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO (b) <b>deft Ventricular Failure</b> DUE TO (c) <b>Hypertensive Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>Edy</b> <b>known</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Gross Obesity (5ft 6" 320 lbs.)</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/23/1967</b> to <b>2/23/1967</b> that (I) (we) last saw the deceased alive on <b>2/23/1967</b> and that death occurred at <b>7:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3-5-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALDWELL A.M.E.</b>	23d. LOCATION (City or Town) (County) (State) <b>Orangeburg S.C.</b>
24. FUNERAL DIRECTOR <b>Frederick Jolley - Jersey Rd. #2 Salisbury</b>		25a. REC'D BY REG. CLERK <b>MAR 3 1967</b> DATE	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02916

02908

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.F.D. #1 Salisbury</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Levin</u> <u>C.</u> <u>Waters</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>February 21</u> <u>1967</u> Day Year	
<b>5. SEX</b> <u>M.</u>		<b>6. COLOR OR RACE</b> <u>C.</u>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec. 25, 1901</u> Yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Minister</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>	
<b>13. FATHER'S NAME</b> <u>Daniel Waters</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Church</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>221-10-6008</u>	
<b>17. INFORMANT</b> <u>Elva Waters R.F.D. 1 Salisbury Md.</u>		<b>18. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>19. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c):) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>X</u> DUE TO <u>Prostatic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. } DUE TO _____ (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>Indefinite</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>21 Jan 1967</u> <b>to</b> <u>21 Feb 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>21 Feb 1967</u> <b>and that death occurred at</b> <u>5:00 p.m.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>E. A. PARNELL</u>		<b>22b. DATE SIGNED</b> <u>28 Feb 67</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>E. A. PARNELL</u>		<b>22d. ADDRESS</b> <u>6524 W. MAN Sky Tr</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/25/1967</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Calvary</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Fruitland Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Clifton F. Stewart</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02917

CERTIFICATE OF DEATH

02909

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY in 1b <b>Adm. in 1 D 2/12/67</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>			d. STREET ADDRESS <b>304 Oak Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <b>MARGARET (NMI) WEIMER (Wymere)</b>			4. DATE OF DEATH Month Day Year <b>February 13 1967</b>		
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1900</b>	9. AGE (In years last birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>11 8</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>(Unk.) Weimer</b>			14. MOTHER'S MAIDEN NAME <b>(Unk.)</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>262-03-9050</b>		17. INFORMANT Address <b>Sarah V. Methvin (Daughter) 304 Oak Street, Salisbury, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY DEPRESSION + ARREST</b> DUE TO (b) <b>CARCINOMA OF BREAST</b> DUE TO (c) <b>20 MONTHS</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH <b>20 MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/12/67</b> , 19 <b>67</b> , to <b>2/13</b> , 19 <b>67</b> , that (I) (we) lost the deceased alive on <b>2/13</b> 19 <b>67</b> and that death occurred at <b>2:40</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>B.C. Sanders</b>			22b. DATE SIGNED <b>2/13/67</b>		22c. PHYSICIAN'S NAME (Type) <b>B.C. SANDERS</b>
22d. ADDRESS <b>Peninsula General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>Feb. 20 / 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>J. Wm. Lee's Son's Co.</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>			25a. REC'D BY REGISTRAR <b>FEB 21 1967</b>		
			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

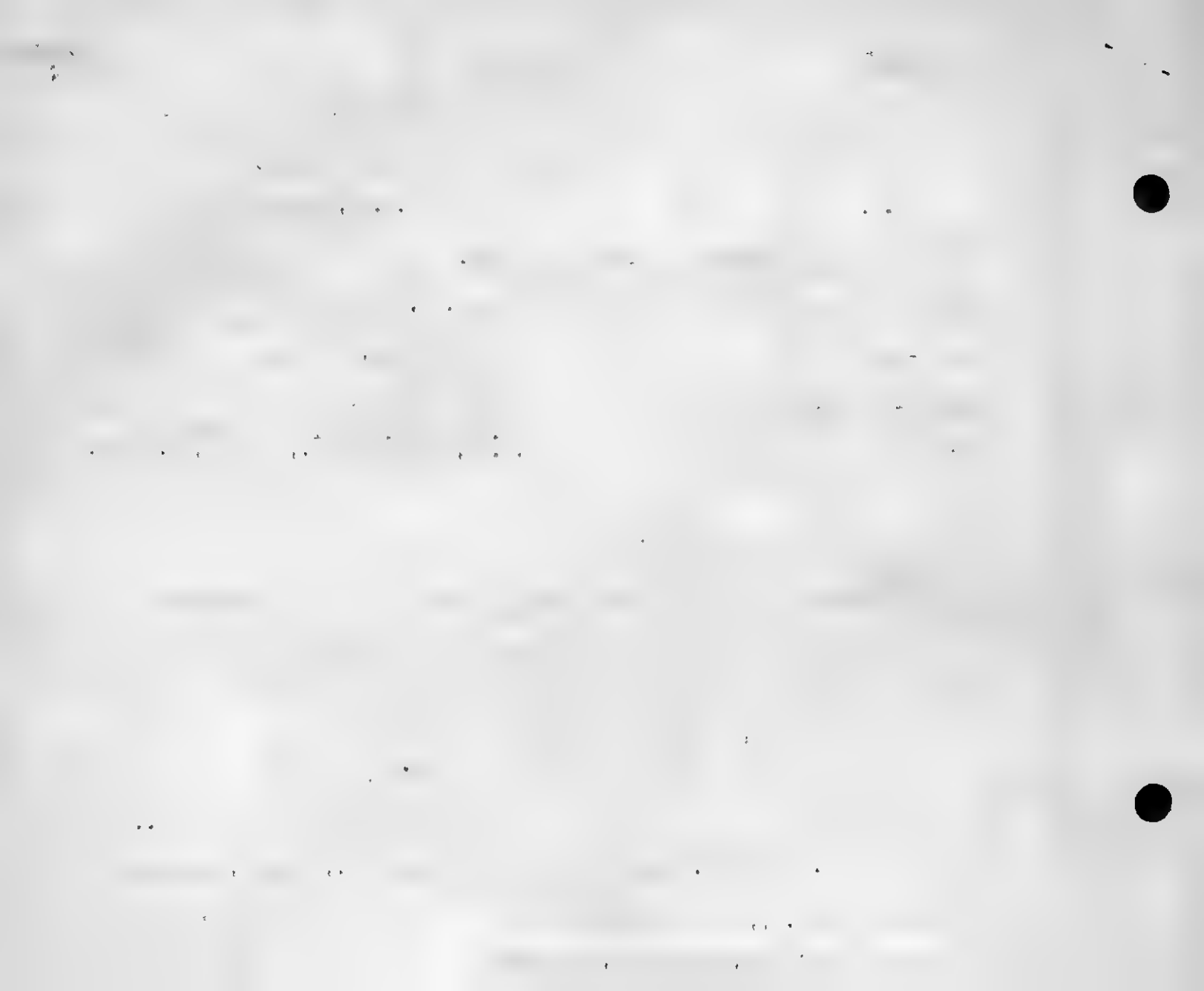
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02918

## CERTIFICATE OF DEATH

02910

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Delmar (Rural)</b> 22.1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D. #3</b>				d. STREET ADDRESS <b>R.D.#3, RumRidge Road</b>			
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>AMELIA</b> Last <b>WELLS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 3, 1880</b>	
9. AGE (in years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pittsville, Maryland</b>	
13. FATHER'S NAME <b>Benjamin Parsons</b>				14. MOTHER'S MAIDEN NAME <b>Martha West</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				17. INFORMANT <b>Mrs. Nicie E. Rennie (Daughter)</b> <b>R.D.#3, RumRidge Rd., Delmar, Md. (Del. 19940)</b>			
16. SOCIAL SECURITY NO.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> DUE TO (b) <b>arteriosclerotic Heart disease</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>10 YRS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1/28</b> , 19 <b>66</b> to <b>2/1</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>2/1</b> , 19 <b>67</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Joseph A. Elliott</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 7/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Joseph A. Elliott</b>				22d. ADDRESS <b>714 West St., Laurel, Delaware</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 7, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Farlow Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Pittsville, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>FEB 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John L. Judge</b>	



02919

## CERTIFICATE OF DEATH

02911

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b> d. STREET ADDRESS <b>1207 Dorchester St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIJAH</b> First Middle Last <b>Whitehead</b>		4. DATE OF DEATH Month Day Year <b>February 28 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 27, 1907</b> 9. AGE (in years last birthday) <b>59</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automotive</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Northampton County, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Whitehead</b>		14. MOTHER'S MAIDEN NAME <b>Maude Richardson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>213-14-6094</b>	
17. INFORMANT <b>Mrs Christine Whitehead,</b>		Address <b>Pocomoke Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of myocardium</b> DUE TO (b) <b>Coronary Artery Thrombosis</b> DUE TO (c) <b>Coronary atherosclerosis</b> INTERVA. BETWEEN ONSET AND DEATH <b>38 min</b> <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> , 19 <b>67</b> , to <b>2/28</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2/28</b> , 19 <b>67</b> , and that death occurred at <b>9P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>David J. Gilmore</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>David J. Gilmore</b>		22d. ADDRESS <b>Medical Center, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-3-1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>First Baptist</b>	23d. LOCATION (City or Town) (County) (State) <b>Pocomoke City Wor. Md.</b>
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR <b>Robert H. Watson</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAR 6 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02920

## CERTIFICATE OF DEATH

02912

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Since 9/28/66</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pine Bluff State Hospital</b>		d. STREET ADDRESS <b>-</b>	
3. NAME OF DECEASED (Type or print) First <b>Flora</b> Middle <b>Mae</b> Last <b>Wilkins</b>		4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1892</b>
9. AGE (in years last birthday) <b>74 yrs</b>		10. F UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Wicomico Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elijah Tubbs</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Truitt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>216-56-0351</b>	
17. INFORMANT <b>Records of Pine Bluff State Hospital, Salisbury, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic cardio vascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>Sept. 28, 1966</b> , to <b>Feb. 9, 1967</b> that <del>it</del> (we) last saw the deceased alive on <b>Feb. 9, 1967</b> , and that death occurred at <b>8:25 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>E. P. Ritchings</i>		22b. DATE SIGNED <b>Feb. 9, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. P. Ritchings</b>		22d. ADDRESS <b>Pine Bluff State Hospital Salisbury, Maryland 21801</b>	
23a. BURIAL, CREMATION, or other disposition <b>Buried</b>		23b. DATE THEREOF <b>2/12/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Hope</b>		23d. LOCATION (City or Town) (County) (State) <b>Willards Md.</b>	
24. FUNERAL DIRECTOR <b>Peter Whaley</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 14 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02921

## CERTIFICATE OF DEATH

02913

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Delmar Road</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>EVELYN</b> Last <b>WILLIAMS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1926</b>	9. AGE (In years last birthday) <b>40</b> yrs.	IF UNDER 1 YEAR Months <b>9</b> Days <b>27</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George T. Williams</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Ennis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT Address <b>Mrs. Mamie Williams (Mother)</b> <b>Fruitland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 7543 DUE TO (b) <b>Pulmonary Artery Thrombosis</b> 465X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Interatrial Septal Defect</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia, Cyanosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs old. Congenital</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/25</b> <b>1967</b> to <b>2/27</b> <b>1967</b> , that (I) (we) last saw the deceased alive on <b>2/27</b> <b>1967</b> , and that death occurred at <b>3</b> PM, from the causes and on the date stated above.							
22a. SIGNATURE <b>Rufus S. Gardner, Jr.</b>				22b. DATE SIGNED <b>Feb. 28, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Rufus S. Gardner</b>	
22d. ADDRESS <b>Medical Center, Salisbury, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 2, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smullen Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Worcester Co., Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>			
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FOR STATE  
HEALTH DEPT.

02922

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02914

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deers Head State Hospital</b>		d. STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>W.</b> Last <b>WINDSOR, SR.</b>		4. DATE OF DEATH Month <b>2</b> Day <b>20</b> Year <b>67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1901</b>
9. AGE (In years lost birthday) yrs. <b>65</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Wingate, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Hudson Windsor</b>		14. MOTHER'S MAIDEN NAME <b>Anna Frances Adams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-18-5215</b>	
17. INFORMANT <b>Mrs. Tressie E. Windsor, Same as 2. abcd</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>491X</b> IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Paraplegia, secondary to spinal cord lesion, lower thoracic</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>Boating accident</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>PM</b> <b>8-24</b> 19 <b>66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Tangier Sound</b>		20f. (City or town) (County) (State) <b>Crisfield Somerset Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		22. DATE SIGNED <b>February 23, 1967</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		Address (Street, city, town, or county) <b>409 Camden Ave., Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 23, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Marion, Md.</b>	
24. FUNERAL DIRECTOR <b>Bradshaw Funeral Home, Crisfield, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11250

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*Handwritten signature*

1321 3 3 337